State of Maryland / Department of Health and Mental Hygiene 2004 05001 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day **Physician** NATHE.N RICARDO DAVIS JAN. 24, 2004 7:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital MONTGOMERY Takoma Park If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Wash. DC **Funeral** 1**⊠**M 2□F 41 Director 578-94-2223 July 6,1962 Usual Residence of Decedent 10a. State 10b. County rai', or items 23a or 28e-f show Examiner rount be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8748 Ravenglass Way 20886 nit. Pages 1 and 2 should be filed within 72 hours after death vartment of Health and Mental Hygiene.
ortant: if item 27 is marked other than "natural; or items 23s injury or other traumatic event, the Mactical Examinar faults. Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. W Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Self-Employed Construction 2 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20886

Worth Village, MD 2 Gathen Davis 19a. Informant's Name/Relationship (Type, Print) Mary Jackson (Mother) 8748 Ravenglass Way, Montg. Village, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Important: If any injury of Metro Funeral Srv 2/7/04 Alexandria, VA 21. Signature of Funeral Service Limit 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 110 que 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Donot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION **Physician** SILATERAL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence ot): Box 68760. Physician/Medical as the t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by RECURRENT 1 Yes 2 No 3 Probably 4 Unknown RESPIRATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; MELLITUS, 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, tactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 01.24,2004 - TOLEDO TEILLACE 30. Name and address of person who completed cause of death (flem 23a) Tage, Print) 31. Date filed (Month, Day, Year) FEB 0 4 2004 32 Registrar's Signature Registrar

	1 - State Registrar	o /First ****	h 1 c = 41			Ce	rtificate of	Death		2. Date of De	Reg. No.			500 Time of Death
an	1. Decedent's Nam			iana						Month	Day	Yes	ar	
al	Angelo  4a. Facility Name (	Joseph If not institution		iiano et and num	ber)		4b. City, Town,	or Location of		Januar		200 County of D		:10 A
er	23 Windl				,			nersbur				ntgon		
	5. Social Security N		6. Sex			. last birthday)		r   If Under 2		8. Date of Bi (Month, D.				(State or Foreig
	082-26-85		1LALM	2 F	70	Yrs.				June 1	0, 19	933 N	lew Yo	ork
	Usual Residence o	10b. County			10c. C	ity, Town or Lo	ocation						10d. Ir	nside City Limits
ğ	MD	Montg	omerv	•			Gaithers	huro					1	XYes 2 □ No
Funeral Director	10e. Street and Nu		,				10f. Zip Code				10g. Citi:	zen of What	Country?	
,	23 Windh	orooke	Circl	е				208	79		Unit	ed St	ates	
	11. Marital Status			Armed Fore		J.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origi ban, Mexican,	in? (Spe Puerto f	cify Yes or Ne Rican, etc.)	0-	14. Race - A Black, W	merican In /hite, etc.	idian,
Dy L	1 ☐ Never Marr 3 🔀 Widowed			1 □ Yes If Yes, Give Year or Da			1□Yes 2∰N	Specify:				Specify:	White	2
	o Es Widowod	15. Deceden				16a. Dece	dent's Usual Occi	upation			16b. Kii	nd of Busine		
pier	(Spec	cify only highe	- T	mpleted) College (1-	4or 5+)	(Give	kind of work don DO NOT use retir	e during most ed)	of workir	ng				
Completed				5+		Soc	ial Work					tgome	ry Co	unty
0	17. Father's Name Carmen I									(First, Middle				
0				Defeat)		405 14-70				e Zac			7.0.4	
	19a. Informant's N Michele				er	3478	ng Address <i>(Stree</i> August	a Drive						9)
	20a. Method of Dis		, -				osition (Name of matory or other pi	20		ate		cation - City		State
	1 A Burial 2 14 □ Donation			oval from S	late   _		matory or other pi s Cemete		Janu 200	ary 30 4		antow	n . M	m
	21. Signature of Fi	<u></u>							De	Vol Eu				
	TRA	cuA.	Stew	u)		D	2. Name and Add eer Park	Drive	, Ga	ithers	burg,	MD 2	0877	East
	23a. Part1. Enter to shock, or hea	the isease, o art ailure. List	r complicat	ons that ca ause on ea	used the dea	th. Do not en	ter the mode of dy	ing, such as c	ardiac o	r respiratory a	arrest,		Inte	roximate rval Between
	Immediate Cause disease or condition	on		С	ardiac	Arrhy	thmia							set and Death Ours
	resulting in death)			Due to (c	r as a conse	quence of):								
	Sequentially list co	onditions,	b		oronar ras a conse		ry Disea	se					Ye	ars
Examine	Cause. Enter Under Cause (Disease or	erlying r injury	₹				rolemia						Ve	ars
Ya.	that initiated event resulting in death)	\$	c		r as a conse								10	ulb
To to			<b>L</b> d	H	yperte	nsion							Ye	ars
Medi	15 55 141 5													
Physician/Medic	IF FEMALE: 23b. Was deceder in the past 12		23c.		ome of pregr th 2   Fet		∃Ectopic pregnan	су			1,12	3d. Date of	delivery Day	Year
SICI	1 ☐ Yes 2	□No		4□Pregna 9□Unkno	nt at time of wn	death 5[	Other (specify)					WOTET	Oay	7 041
	Part II. Other signi		ons contrib	utina to de	ath but not re	sulting in the u	inderlying cause o	uven in Part I.		23e. Did	tobacco u	se contribut	e to the ca	use of death?
d by	Multipl			_		-		,						4 Unknow
Completed	Myelofi							-		24a. Was				indings availabl
Ĕ				эртеп	eccomy					auto perf	DSV	prior	to complete?	tion of cause of
Be C	Prostat 25. Was case refe					-		26 Place	of Death	(Check only		101	Yes 2□	No
0	examiner? 1 ☐ Yes 2 🖫	No	Hos	oital:	patient 2	☐ ER/Outpatie	nt 3□ DOA C	ther: 4 Nur				Other (5	Specify)	
	27. Manner of Dea	th 5 Pendi		28a. Date o		28b. Time o	of 28c. inj			28d. Describe				
Salle	2 Accident	invest	igation					□Yes 2□N	lo					
Certification:	3 🗍 Suicide 4 🗍 Homicide	6 🗌 Could detern		28e. Place buildin	of Injury - At I g, etc. <i>(Spec</i>	home, farm, st cify)	reet, factory, offic	9	2	28f. Location City or To	(Street and wn, State)		r Rural Roi	ute Number,
edical Ce	29a. Certifier (Check only	1 X Certifyi 2  Medicai	ng Physici I Examiner	: On the ba	sis of examin	nowledge, dear	th occurred at the	time, date and	place, a	and due to the	cause(s) , date and	and manner	r as stated due to the	cause(s)
Med	one) 29b. Signature and	d title of certific	er	and mann	er stated.		29c. Lice	nse number			29d. Date	e signed (M	onth, Dav.	Year)
		- C		4		MC	1					ary 2	-	

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month PBY, Year) 2004

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

# Amended Part II, nls, 02/09/04, Allegany Co. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Ragistrar	State of Mary	land / Depa <i>Cei</i>	artment of H tificate of L	ealth and M Death	fental Hygier Reg.	ne 2004	05003
	Physici	an	Decedent's Name (First, Middle, Las	Miriam	Daley				Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		Duicy	4b. City, Town, or	Location of Death		4c. County of Death	1000
	LXamiii		SACRED HEAR		TAL	Cumb		1D	ALLEG	
	Funeral Director		5. Social Security Number 6. Security Number 1	ex 7. Age (In □M 21X(F	yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	oar) Coui	place (State or Foreign ntry) Mary land
	D		Usual Residence of Decedent					August 08		
	show	2	10a. State 10b. County		c. City, Town or Lo	cation	Υ			10d. Inside City Limits 1   Yes 2   No
	28a-f	Director	Maryland A  10e. Street and Number	llegany		10f. Zip Code	Lonaconing		Citizen of What Cour	ntry?
	th with		9 Wes	t Railroad Street			21539		U	SA
36	hin 72 hours after death with the Maryland B. Madical Examinat must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2.2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	etc.
21215-0036	2 hours	ted t	15. Decedent's Ed	lucation	16a. Deced	ient's Usual Occupa	ition	16b	. Kind of Business/In	White dustry
215	within 72 ene. than "na! he Medic	Completed	(Specify only highest gra	College (1-4or 5+)	life.	kind of work done d DO NOT use retired,	)	mg		
121	TO 100 MILES		8 17. Father's Name (First, Middle, Last)			ŀ	Iomemaker	e (First, Middle, Maid		ome
lan	ed is pos	To Be		illiam Douglas S	oiker				Viola Barnes	
Maryland	and and le m	-	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rura		ity or Town, State, Zip	Code)
	s 1 and 2 if Health item 27		Thomas M. 20a. Method of Disposition		0b. Place of Dispo				Maryland 21 Location - City or To	
nor	of of H		1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crer	natory`or other place	9)	February 06,		
Baltimore,	글론원공.		21. Signature of Funeral Service Licen			set Memorial . Name and Addres	s of Facility	2004		d, Maryland
ä	Depa Impo sny i		Jans E. Met	enje					Home P.A. 8 E	E. Main
Р			23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ent	er the mode of dying	g, such as cardiad	or respiratory arrest,	14,21337	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a aspera	11145	phon	on 15			) Ddays
ŀ	Examiner			as pira	HIM Dhi	umnia				10 days
_	D is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):	0m/ 10	( ) (			. 11 1 2 2 2
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8760,	ate be executed hysician and the burial-transit	dical E	(	d						
Θ	intificating physes as the	Medi	IF FEMALE:							
O. Box	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
Δ.	es that igned by be deta	by Ph	Partil Diber significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause give	n in Part I.	23e. Did tobacc	co use contribute to the	he cause of death?
ords	w require been sig should b		Sastretta Car	cinoma ot	the 14	ng		1 🗆 Yes	2□No 3⊅Prob	pably 4 Unknown
of Vital Records,	The law ate has b page 2 s	Completed						24a. Was an autopsy performed	prior to co death?	ppsy findings available impletion of cause of 2 No
Vita	2 8 6	Be	25. Was case referred to medical examiner?	Hospital:		Othe	VC-	(Check only one)		
o	g Phys er this eral di	i: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Ye	2 ER/Outpatien	3 DOA	4   Nursing no	me 5 Residence 28d. Describe how in	e 6 □Other (Specification)	y)
ion	Attending ir death, ector: Alter by the fune.	atio	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation	1	ar) Injury		/es 2 □No			
Division	i Pit o	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
-	Hospital 4 hours a Funeral [		29a. Certifier 1 Certifying Ph	ysician: To the best of m	y knowledge, death	occurred at the tim	e, date and place	and due to the cause	e(s) and manner as s	tated.
	the Horhin 24 h	edical	(Check only 2 Medical Exam	niner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my op	pinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
	To the P within 24	Σ	29b. Signature and title of certifier	number	29d.	Date signed (Month,	Day, Year)			
	6		Nemal 1:V	Mary C	(Item 93a) /T:	Print)	1 4 0 5)		erruary	3 2004
	nks Sta	to	30. Name and address of person who only a second person who are second person person who are second person perso	32. Registrar's	14407	MAZEL	1 BD	CUMBE	PLAIND	MD 21502
40	Registr		31. Date filed (Month, Day, Year) FEB 0 5 2004	the same	P.	parks				

			1 - For State Registrar	State of Mar	yland / Dep <i>Ce</i>	artmer ertificat	nt of H	lealth a	and M	ental Hy	giene Reg. No.	200	4 050 <b>04</b>
	Dharata		1. Decedent's Name (First, Middle, Las	it)						2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medi		Sophronia Marie	e Dodson		,				Januar	y 31	, 2004	11:05a M
Ì	Examir	ner	4a. Facility Name (If not institution, give					Location of				County of Dea	
			5459 Mt. Holly		(la con la ná húmh de c		st N	ew Ma		O. Data of Bird		orches	
	Funeral Director		5. Social Security Number 6. S. 214–32–5849	ex □ M 2154 F 7. Age (	(In yrs. last birthday 89 Yrs.	Months		Hours	Min.	8. Date of Birt (Month, De	y, Year)	1 Q1 / N	thplace (State or Foreign Jountry) Maryland
			Usual Residence of Decedent		09				i	August	. 20,	13141	arytanu
	Maryland -f show		10a. State 10b. County		I0c. City, Town or L								10d. Inside City Limits
5	e Mar	cto	MD Dorche	ster			East	New .	Marke	et 			1 ☐ Yes 2 X No
X	ith th	Oire	10e. Street and Number	- 7		10f. Zip	Code	04.60	. 4			zen of What Co	ountry?
2	ath w	Funeral Director	5459 Mt. Holly F					2163				.S.A.	
1	er de	-du	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No	er in U.S. 13.	Was Dece If Yes, spe	dent of Hi city Cuba	ispanic Orig n, Mexican	gin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	.   1	4. Race - Ame Black, Whit	
36	irs aft	by F	3 Midowed 4 Divorced	If Yes, Give* Year or Dates:		1 🗆 Yes	2 No	Specify:				Specify: W	nite
Š	72 hours after death with the natural', or items 23s or 28s digal Examinist institut by Dall	ted	15. Decedent's Ed		16a. Dece	edent's Usu	al Occupa	ation	A = 4 = 4 . i =		16b. Kir	nd of Business	/Industry
215	within 7 ene. than "n	pie	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT u	se retired	)	t or workin	ng .			
7	e filed within al Hygiene. I other than '	Completed	7			retai	l cle					rtment	store
pu	be filed within 72 hours after death with the Marylan stal Hygiene. od other than "natural", or items 23a or 28e-f show svent, the Medical Examiner man be notified at	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden .	Sumame)	
3	2 should be and Mental Is marked of eumatic sv	5	James Irving Hur		10h Mail	to a Antoliano	/Street			bard	City	Town State	Zin Codel
Maryland 21215-0036	d 2 st th and 7 Is r treun		Rosalie Dolan	daughter		•				ast New			
e,	1 an Heal lem 2		20a. Method of Disposition	daugiter	20b. Place of Disp			-		ate		cation - City or	
<u>o</u>	ages ant of it: If II		1 Surial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	cometery, cre Dorcheste			T T	لا	/3/04	Cami	bridge,	MT
Baltimore,	nit. F antme ortan Injur		21. Signal of Funeral Service Com							mas Fu	nera	l Home	P.A.
B	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury or other treumatic as <u>once.</u>		I for in lor	m-						oridge,		21613	
			23a. Part. Enter the disease, or com- shock, or heart failure. List only	plications that caused the	ne death. Do not en	iter the mod	de of dyin	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
) i	Physician		Immediate Cause (Final disease or condition	a Ad	vance	De	me	e da					Onset and Death
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8760,	death certificate be executed e attending physician and ed for use as the burial-transit	cai		d									
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Ö.	the at	sici	1 Yes 2 No	4 ☐ Pregnant at tir 9 ☐ Unknown	me of death 5	Other (sp	pecify)					WONTH	Day 16a
P.O.	ac ox		Part II. Other significant conditions c	ontobuting to death but	not resulting in the	underbing	Called alve	an in Part I		23e Did to	obacco us	se contribute to	the cause of death?
ds,	signed I	d by	Malnur	,			<b>3</b>				res 2		obably 4 □Unknown
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Re	0 5 0	m E								autop	sy med?	prior to death?	completion of cause of
a	ician: Th certilicate ector, pag	ပိ	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes	2/2/10	1 🗌 Yes	3 Carrie
>	Physician: r this certific ral director,	OB	examiner?	Hospital:	2 ER/Outpatie	nt 3□ D0	Othe	ne.		ne 5 Resid		□Other (Spe	cify)
101	9 Ph	T:u	27. Manner of Death	28a. Date of Injury (Month, Day )	(ear) 28b. Time (	of 2	28c. Injury Work			8d. Describe h			
jo	Attending in death.  ector: After by the fune	atlo	↑ Natural 5 Pending 2 Accident investigation	1	injury	М		Yes 2 □	No				
Division of Vital Records,	r Atti	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	· At home, farm, st (Specify)	reet, factor	y, office		2	8f. Location (5 City or Tow			ural Route Number,
	urs af urs af ura! D												
	To the Hospitel or Attending Physicien: within 24 hours attendeath.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one)  Certifying Ph  (Check only one)	ysician: To the best of endiner: On the basis of endiner and manner state	xamination and/or in	th occurred nvestigation	at the time, in my or	ne, date and pinion, deat	d place, a th occurre	nd due to the o d at the time, o	cause(s) a date and	and manner as place, and due	s stated. to the cause(s)
	o the	Me	29b. Signature and title of certified	and marrier state		290	c. License	number			29d. Date	signed (Mont	h, Day, Year)
	- s - ō		1 Julie	M.	D		DY	1792	4		2 -	3-04	
		13	30. Name and address of person who	completed cause of dea	th (Item 23a) (Type	, Print)							
			NOMAN THANG	or 300 1	AURORA	STRE	ET	CA	grass.	RIDGE	1	190	21613
	Sta		31. Date filed (Month, Pay Year) 4	2004 32. Receirar	s Signature	1							
	Regist	ar	1 7 7 7		The sales	1							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ician dical	Decedent's Name (	O., TCHD, O. First, Middle, Last)	2, 0 1, 000		Certificate of		2. Date of Dea		Year	3. Time of Death
		ARL ELBUI					Januar			1749 PM
niner	4a. Facility Name (If n 30593 Dee	et institution, give s ep Branch			4b. City, Town, o	or Location of Death			County of Deeth	
al	5. Social Security Nun			e (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birtho	lace (State or Foreign
or	214-92-673	35	M 2□F	37 Y	rs. Months Days	Hours Min.	AUG 4,	1966	MAR	YLAND
	Usual Residence of D 10a. State	ecedent l0b. County		10c. City, Town	or Location				1	0d. Inside City Limits
to	MD	TAL	вот	EA	STON					1 ☐ Yes 2 ☑ No
Director	10e. Street and Numb	per			10f. Zip Code		T	10g. Citize	en of What Cour	ntry?
ai	10420 OLI	CORDOVA	ROAD			21601			USA	
Funeral	11. Marital Status		2. Was Decedent 8 Armed Forces?		<ol> <li>Was Decedent of H If Yes, specify Cub</li> </ol>	Hispanic Origin? (Sp Jan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14	<ol> <li>Race - Americ Black, White,</li> </ol>	
by F	1 Never Married 3 Widowed 4		1 ☐ Yes 2 ▼ N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 No	Specify:		S	Specify: WH	ITE
		5. Decedent's Educ only highest grade		16a. [	Decedent's Usual Occup Give kind of work done	pation	ing	16b. Kind	d of Business/In	dustry
Completed	Elementary/Second		College (1-4or 5	+)	life. DO NOT use retire	ed)	y		ENDABLE	
	12 17. Father's Name (Fi	irst Middle Last)	2	0	WNER OPERA	18. Mother's Name	a (First Middle		CTRIC	
To Be		EARL ELBU	RN .TR.			PATRICIA		WIEDOW 0	omanio,	
-	19a. Informant's Nam			19b.	Mailing Addrass (Street			r, City or T	Town, State, Zip	Code)
	DONNA LEE	ELBURN/	WIFE	10	420 OLD CO	RDOVA ROAI	D, EAST	ON, M	D 21601	
	20a. Method of Dispo	sition Cremation 3 □Re	emoval from State	20b. Place of I cemetery	Disposition (Name of , crematory or other pla		Date	20c. Loca	ation - City or To	own, State
	°4 □Donation 5	Other (Specify)		CHESAPE	AKE CREMAT		-2-2004	STEV	ENSVILL	E, MD
	21. Signature of Fune	eral Service License			FELLOWS, H	ELFENBEIN	& NEWNA	AM FU	NERAL H	OME PA
	23a. Part1. Enter the	disease, or complic	cations that caused	the death. Do no	200 S HAR	RISON ST	EASTON,	MD 2	1601	Approximate
	Immediate Cause (Fi	failure. List only on inal	e cause on each lin	10. - c + Shi	1.10.	1 2	- h =			Interval Between Onset and Death
	disease or condition resulting in death)	C a	Due to (or as	a consequence of	tgen wou	ina of	1451			
	Secuentially list cond	fitions b							-	
xamlner	if any, leading to imm cause. Enter Underly Cause (Disease or in	nediate ying	Due to (or as	a consequence of	):					
E	that initiated events resulting in death) La		. Due to (or as	a consequence of	·):					
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ш	IF FEMALE: 23b. Was decedent print the past 12 m	pregnant	3c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Petal death	3 ☐Ectopic pregnanc	у		23	3d. Date of delive	
m	23b. Was decedent print the past 12 mm 1 Ves 2 1	onths?		2 Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify)	у		23	3d. Date of delive Month	ory Day Year
Physician/Medical E	23b. Was decedent p in the past 12 m 1 Yes 2 1 9 Unknown	onths?	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death time of death		,	23e. Did to		Month	
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To Be Completed by Physician/Medical E	23b. Was decedent printhe past 12 m 1	d to medical  Pending investigation 6 Could not be	ospital: 1   Inpatie  28a Date of Injur (Month, Da)	2 Fetal death time of death time of death ut not resulting in the control of the	oatient 3□ DOA Other of 28c. Injury Wo	26. Place of Deather: 4 Nursing Hory at rk?	24a. Was a utop performent of the control of the co	obacco use  'es 2   an sy med? 2 □ No ne)  lence 6 [ low injury of the box	Month  e contribute to the con	Day Year  ne cause of death?  ably 4 Dunknown  psy findings available included of cause of 2 No  At scene
o Be Completed by Physician/Medical E	23b. Was decedent print the past 12 mr. 1 Yes 2 19 Unknown  Part II. Other signific  25. Was case referre examiner?  27. Manner of Death 1 Natural 2 Accident	ant conditions conditi	ospital: 1   Inpatie  28a Date of Injur (Month, Da)	2 Fetal death time of death time of death time of death ut not resulting in the control of the c	obtailent 3 DOA of the of 28c. Injury	ven in Part I.  26. Place of Deather: Al □ Nursing Hory at rk? Yes 2 ☑ No	24a. Was autop performence of Residual Check on the Check on the Check on the Check on the Call Call Call Call Call Call Call Cal	obacco use  (es 2 X  an sy med? 2 No ne) lence 6 fow injury of the sy street and m, State)	Month  e contribute to the con	Day Year  ne cause of death? abby 4 Unknown  psy findings available  mpletion of cause of  2 No  At scene  I Route Number,

State Registrar

DHMH 17 Rev 1/2001

Tasha Z Greenberg
31. Date filed (Month, Day, Year)
FEB 0 4 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar 05006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day February 5, **Physician** Ellen. Erskine 2004 9:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Genesis Eldercare- Layhill Silver Spring Montgomery 7. Age (In yrs. last birthday)
92 Yrs. Months Days Hours Min. Nov. 4, 5. Social Security Number 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🛛 F 129-24-9306 1911 Director Panama Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location ahow. 10d. Inside City Limits notified at 1 ☐ Yes 2 █ No Directo Maryland Montgomery Silver Spring 28a-f 10e. Street and Number 10g. Citizen of What Country? ŏ the Medical Exercitor must be 8 Dunsinane Court 238 20906 IISA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married 0 Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: Black Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse's Aid Health Care injury or other traumatic avant, 17. Father's Name (First, Middle | ast) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be nent of Health and Mental ant: If Itam 27 is marked o Amos Erskine Margaret Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline E. Lindo/ Niece 8 Dunsinane Court, Silver Spring, MD 20906 Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State February 12 \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Silver Spring, MD 21. Signature of Juny al Service L 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Coronary Insufficiency 30 minutes /Medical Due to (or as a consequence of): **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5 years Due to (or as a consequence of) Examine that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death Month Day Year signed by the a 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 2 No Division of Vital : After this certifica e funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \Sigma\) Nursing Home 5 \( \sigma\) Residence 6 \( \sigma\) Other (Specify) P 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Attending 1 Natural Injury 5 🗀 Pending death. 1 Tes 2 No 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or A within 24 hours after To the Funeral Directions 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dewett Morriso mi D47682 February 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bennett Morrison M.D. 2901 Olney-Sandy Spring Road, Olney, MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 06 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 05007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 2004 2:15 P M Elisabeth Wakeman Edmonson January 28, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 406 Cedar Ridge Drive Oxon Hill Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nonths Days Hours Min. Sept. 2, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💥 F 231-03-0878 89 1914 Virginia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f shov the Medicul Evantmer must be notified at 1X Yes 2 No Alexandria Virginia Alexandria Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 W. Bellefonte Ave. 22301 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Is marked oth any injury or other traumatic evant once. Samuel Houston Wakeman Arlene Menefee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rae A. Edmonson, III - Grandson 103 W. Bellefonte AVe, Alexandria, VA 22301 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \*4 □Donation 5 □ Other (Specify) National Memorial Park Feb.2,2004 Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Everly-Wheatley Funeral Home 1500 W. Braddock Rd, Alexandria, VA 22302 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1136 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrovaseslar Accident Physician Imonth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of. To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 MOther (Specify) Home Relative s Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 ☐ Homicide 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certilier 0101053428 1-30-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) althyn Dietz 6412 Beviah Alexandra VA 22310 31. Date filed (Month, Day, Year). 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05008 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 45 AM **Physician** 2004 30 FRENCH Helen H/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sunnise Frederick Frederick +55isted 410109 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Days Hours 20922435 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f ahow may injury or other traumatic event, the Madical Examiner must be notified at once. 1 Tes 2 No Frederick Frederick Md Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21102 Drive 990 Watertord Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) DEPT. OF HEALTH College (1-4or 5+) Efementary/Secondary (0-12) SECRETALIA-L 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ANNA ALEX HAMALYAK YUNK O 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9.0. BX GREG-FRENCH SON BAKERTON, WW 25140 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State BERWICK CEM. 2.2-04 BERWILK, \* 4 ☐ Donation 5 ☐ Other (Specify) HINES- RINILLDI 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11800 HAMPSHIRE AUY - SILVER STRING 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 2017 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes No 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes . Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Funaral Director: After the completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 Yes investigation within 24 hours after death. To the Funaral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of eartifier address of peregn who completed cause of death (Itam 23a) (Type, Print), Toll 1 1216 1501/ 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 4 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05009 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 11:40 P<sup>M</sup> 2004 February Janette Marie Fearon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gaithersburg Montgomery 1 Thorburn Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under Months Days Hours 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖸 F 5. Director 1963 Pennsylvania 203-50-0801 40 Nov. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County rthan "natural", or items 23e or 28a-f ehov the Medical Examiner must be notified at 1 ☑Yes 2 ☐ No Directo Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 United States l Thorburn Road Funeral filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🔯 No 1 ☐ Yes 2 ☑ No Yes, Give Specify: Completed by 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) 4 Civil Engineer Engineering other mit. Pages 1 and 2 should be file partment of Health and Mental Hy portant: If liem 27 is marked oth y injury or other traumatic event e.e. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Joseph Kane Dorothy Bednarczyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth B. Fearon 1 Thorburn Road, Gaithersburg, MD 20878 (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) St. Mary's Cemetery Rockville, Maryland 2/7/2004 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service er the one se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC **Physician** COLON CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-t Due to (or as a consequence of) Physiclan/Medical 38 attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2 XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s has autopsy performed? certificate 1 ☐ Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 ☐ Yes 2X No this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō thin 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. ţ within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Joseph M. Haggerty mp D 32407 February 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph M. Haggerty, M.D., 9707 Medical Center Drive, Rockville, MD 20851 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 04

Maryland 21215-0036

Baltimore,

Box 68760.

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Division of Vital

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State of Maryland / Department of Health and Mental Hygiene 2004 05010 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** 6:45 28, 2004 Dorothy Conelley Formant January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Min. Hours 1 □ M 2 🖾 F 77 Dec. 14, 1926\_ Washington, DC 577-40-8017 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. Count 10a. State s 23a or 28a-1 shov 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13336 Foxhall Drive 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If item Z7 is marked other than "natural", or item any injury or other traumatic event, the Mudical Examinations. Black, White, etc. 1 Never Married 2 → Married 1 Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Medical Editor 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edith Faye Robinson George Vincent Brenneman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13336 Foxhall Drive, Silver Spring, MD 20906 Dino Formant/ Husband 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stete 20a. Method of Disposition January 31 cemetery, crematory or other place) Parklawn Memorial Park 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) 2004 Rockville, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. sceres 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Septic Shock day /Medical Due to (or as a consequence of): **Examiner** Urinary Tract Infection 1 day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit Pneumonia 1 day Due to (or as a consequence of): sician a ivision of Vital Records, P.O. Box 68760 Physiclan/Medical the phys IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 Yes 2 No 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 XUnknown cate has been sig page 2 should b General Debility, Bedridden Status, Anemia Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 1 Yes 2 No After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of or Attending 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident after death Diractor: the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel within 24 hours at To the Funeral Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one) 29d. Date signed (Month, Dey, Year) and title of certifier 29c. License number 29b. Signature 60 January 29, 2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohsin Ijaz M.D. 11119 Rockville Pike, Suite 100, Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 14 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 27, 2004 8:20 A M **Physician** Clarence Ray Forsht /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel County Edgewater Millennium at South River | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | April 9, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex Year) 921 **Funeral** 1<del>∏</del>M 2□F 213-16-4421 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County Show s 23a or 28a-f shows ust be notified at 1 ☐ Yes 2 No Director Sarasota Florida Sarasota County 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number U.S.A. 34232 422 Oak Hill Circle death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in US Armed Forces? 1942 1 MYes 2 □ No If Yes, Give Year or Dates: 1945 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 5 1 ☐ Yes 2 No Specify: Specify: White ۾ 3 ☐ Widowed 4 ☐ Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Metallurgy Research Technician Federal Government permit. Pages 1 and 2 should be filled wi Department of Health and Mental Hygien Importent: If item 27 is marked other the any njury or other treumatic event, I.E.I. 2005. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Ella Gunzalus Samuel Irving Forsht 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 422 Oak Hill Circle, Sarasota, Florida 34232 Jewel Forsht (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Feb. 2,2004 | Cheltenham, Maryland Maryland Vets. Cem. \* 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licensee 8125 Southern Maryland Blvd., Owings, MD 20736 Michael W. Leely 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arrhy thmig 10 minutes ardiac Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): more than Examiner ardionnyo Yen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner thar sician and burial-transit or Attending Physicien: The law requires that the death certificate be executed Ordialy that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Rena Chronic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ongestive page 2 autopsy performed? 2 🗆 No Hypothyroidicm 2 No 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ £P/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 50653 127/2004 eyou

State Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

31. Date filed (Month, Day, Year) JAN 30 2004

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 2004 05012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Fuller 0630 AM 200 January ana Louise /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown, Washington County Washington County Hospital

5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🕱 F 1919 West Virginia 84 Director 220-64-7003 Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a State r than "natural", or tems 23a or 28a-f show the Medical Examiner must be notified at 1 TYes 2 No Director Maryland Washington Boonsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code be filed within 72 hours after death with 8507 Mapleville Road 21713 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2X Married Specify White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Homemaker Personal Residence jes 1 and 2 should be filed of the the state of Health and Mental Hygie of Health and Mental Hygie of Her I item 27 Is marked other I or other traumatic syent, IL. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Horace L. Renner Ella Mae Anderson ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Nelson Fuller/Husband 8507 Marleville Rd. Boonsboro, Maryland 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite 1 Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park Jan. 27,04 Hagerstown, Maryland \*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 23a. Part1. Enter the leease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NEUMONIA 41 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760. ding physiciar the t use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deeth 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ been signe should be 1 Yes 2 No 3 Probably 4 Conknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1□ Yes 2X No certificate director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 2 this After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident Director: d in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗍 Homicide hours after ō To the Hospital To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 24 within 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, Waryland 1126 Opal Court Wa Sec m 31. Date filed (Month, Par Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 104 05013 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician FURTADO** Pauline 4:17 A M 2004 27 /Medical Lanuary 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Washington County Hospital Washington Hagerstown 5. Social Securify Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 X F 215-24-8729 78 Director Feb.8,1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County ed other than "naturel", or iteme 23a or 28a-f show event, it a Mudical Examinar must be notified at 10d. Inside City Limits Maryland Washington Williamsport 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14857 Bottom Road 21795 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant if Health and Mental Hygie Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Braxton Thomas Luewillie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvester Furtado/Husband 14857 Bottom Road Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate permit. Pages:
Department of It
Important: If Ite
ony injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park Jan. 30, 2004 Hagerstown, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) Service Consee 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21. Signatup Williamsport, MD 21795 nor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 21 Ocer **Physician** 100 resulting in death) /Medical Due to for as a consequence Examiner Delyhation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury us to (or as a onsequence of): Examiner transit The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician a hed for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No 2 No or Attending Physiclan: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3□ DOA this Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide filled within 24 hours a
To the Funeral I
completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oak Hill Home AHICED un 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05014 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 28, 2004 11:30 P M Virginia Gertrude Fitzwater /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Homewood at Williamsport Williamsport Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 85 464-14-6521 08/10/1918 Director Arkan<u>sas</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Exantrement the routhed at 1 Yes 2 No Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1501 Kensington Drive 21742 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry should be filled within and Mental Hygiene. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 12 Realtor Realty 8 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland Be William Forgy Malone Gertrude L. Boone 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health at Importent: If item 27 Is any injury or other trau Pages 1 and 2 Gerald Driscoll/Trust Officer 111 S. Potomac St., Hagerstown, MD 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Smithsburg Cremator. | 01/29/2004 Smithsburg, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensels 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Ovarian Cancer disease or condition resulting in death) month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intribulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of) the attending physician Physiclan/Medical as the Box ( IF FEMALE esn n 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached o 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, be 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 1 Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA To within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral or 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 29, 2004 centhea Kettner- Jands me D47451 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) death (Hom 23a) (Type, Print)
14214 Paradise Church Road, Hagerstown, Maryland Cynthia Kuttner-Sands MD 31. Date filed (Month, Day, Year) 432. Registrar's Signature State Registrar JAN302004

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 05015 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 3:00 AM **Physician** Oliver Olindo Fabbri /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Year If Under 24 Hrs. Allegan DEPITE Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2□F Maryland 28-Jul-1915 Director 214-07-5240 88 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State in then "natural", or items 23s or 28s-f show the Medical Exeminer must be notified at Yes 2 No Director Maryland **Allegany** Frostburg 10e. Street and Number 144 McCulloh Street 10g. Citizen of What Country? 10f. Zip Code 21532-U.S.A. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural, or its ury or other traumatic event, the Medical Externina 1 Never Married 2 Married Specify: White 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 □ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) spinning dept. textile manufacturing 10 18 Mother's Name (First Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ဂ Lucindo Fabbri Benilda Castellani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11113 Broken Heart Mine Son 21532-Frostburg Maryland Michael Fabbri 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 20008. Saint Michael's Cemetery 06-Feb-2004 Frostburg 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service Licens Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obstructive Pulmonary Disease years **Physician** Chronic Severe /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit requires that the death certificate be executed and Due to (or as a consequence of): the attending physician Box 68760, Physician/Medical the **use** as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? for 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. | 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 99 3 ☐ Probably 4 ☐ Gnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 25. Was case referred to medical examiner? 2 🗆 No certificate 1 Yes ospital or Attanding Physician: hours after death. unaral Director: After this certifica funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 2 🗆 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funaral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 101 D21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. JESUS TON ROUTE#36 Frostbi Frostburg Plaza, Frostburg, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05016 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Robert James Fick 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Nicomico SAUISBU KEGIONAL IN SULA 8. Date of Birth (Month, Dev. Y Aug. 13, ff Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Year) 953 Funeral Months Days Hours Mary Land i⊠M 2□F 220-76-2090 50 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County other traumatic evant, the Medical Examiner must be notified at 1 XYes 2 □ No Salisbury Funeral Director Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21802 U.S.A. 926 Snow Hill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No 21215-0036 white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) did not work none unknown pe markad other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland es 1 and 2 should be fill of Health and Mental H I item 27 is marked oth Be Martha Norment 10 Earl J. Fick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2720 Toddville Rd., Toddville, MD Earl J. Fick father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges Department of Importent: If it any injury or o ō 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Zion U. M. Churchyard 2/4/04 Toddville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 15 min K. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 0.0 1 ☐ Yes 2 ☐ No signed b 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 No Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Minpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: After 1 Natural 5 Pending investigation after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗋 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number re and itle of certifier D 58658 address of person who completed cause of death (Item 23a) (Type, Print) CARROLL St. SAlisbuny, md MD 100 E 31. Date filed (Month, Dalz Year) 4 ZUU432. Re Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 ft 0.1

			1 - For State Registrar	State of Ma	iryland /	Depa Cer	tificate of	ieaith Death	and Me		eg. No.	2004	05017
	Physici	an	Decedent's Name (First, Middle, La	st)					2	. Date of Deat Month	th Day	Year	3. Time of Death
	/Media		Merle E. G							anuary			8:20 P M
	Examin	er	4a. Facility Name (If not institution, giv		1		4b. City, Town, o		of Death			ounty of Death	
ŭ.	_ A A		Montgomery Go 5. Social Security Number 6.5		OITAL (In yrs. last bi	irthday)	01ney		r 24 Hrs.   g	Date of Birth		ntgome:	
	Funeral Director		579-16-9031	□M 2፟M F	82	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, Feb. 17	, 192	1 Virg	place (State or Foreign http) ginia
	nyland	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Lo	cation					1	0d. Inside City Limits
	Ba-f	Director	Maryland Montgor	nery	01:	ney							1 ☐ Yes 2 ☑ No
	Vib th	Dire	10e. Street and Number				10f. Zip Code			1		n of What Cour	ntry?
	s 23c	erai	18064 Rolling Me	adow Way  12. Was Decedent B	transia II C	142.11	2083		ninina (Consi	6 - W N -		USA . Race - Americ	an Indian
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show many injury or other treumatic event, Ita Madical Examinat Le notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 N  If Yes, Give  Year or Dates:		1	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 A No			can, etc.)		Black, White,	etc.
2	72 ho natur	Completed	15. Decedent's E (Specify only highest gra		16a	. Deced	ent's Usual Occup	ation	st of working		16b. Kind	of Business/In	dustry
2	within one. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	+)		kind of work done DO NOT use retired memaker	d)				Own Hon	
2	filled Hygie other	Co	17. Father's Name (First, Middle, Last	)			memaker	18. Moth	ner's Name /	First, Middle, M		· · · · · · · · · · · · · · · · · · ·	ite
au	id be ental ked c	To Be	Ernest Lloyd	Dodson					Ida D			,	
ary	shou ind M imar	_	19a. Informant's Name/Relationship (		191	b. Mailin	g Address (Street	and Numb			City or T	own, State, Zip	Code)
	atth a		Donna Munson/ Da	ughter			Round H						
nore,	ages 1 a		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special		Parkl	ary, crem awn	sition (Name of natory or other plan Memorial	ce)	Januar	- 1		tion - City or To	
Baltimore,	permit. P Departme Importen eny injur		21. Signature of Funeral Service Lice	·	1	Park Fr	Name and Addre	ss of Fac	2004 lins Fu	ineral	Home	Inc.	Maryland
			23a. Part1. Enter the disease, or com shock, or heart failure. List only		the death. Do							Spring	, MD 20901 Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Respirat	ory Fa	ilur							Interval Between Onset and Death 6 Hours
Ł	/Medical Examiner		Tooling in dealing	Due to (or as a									
	9 1	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Aspirati Due to (or as a			1a						12 Hours
	cuted	Examiner	trial initiated events	Progress	ive Sup	pran	uclear P	alsy					5 Years
68760,	ificate be executed g physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as a	consequence	of):							
687	g phy as the	edical		_d.									
P.O. Box	The law requires that the death cert ale has been signed by the attendin page 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of the control	2 Fetal death		Ectopic pregnancy Other (specify)	′			230	d. Date of delive Month	ory Day Year
	that hed by deta	by Pt	Part II. Other significant conditions of	ontributing to death bu	t not resulting	in the un	derlying cause giv	en in Part	1.	23e. Did tob	acco use	contribute to th	ne cause of death?
rds	w requires been sign should be	ed b	Emphysema, Type I	I Diabetes	Mellit	tus,	Hyperte	nsion	1	1 □ Ye	s 2 🖾 i	No 3□Prob	ably 4 Unknown
Vital Records,	The law re ale has be page 2 sho	Completed			<u>.</u>					24a. Was ar autops perform	y ned?	prior to cor death?	psy findings available npletion of cause of
ta		0	25. Was case referred to medical				*	26 Piac	a at Dooth //	1 Yes 2		1 🗆 Yes	2 No
>	Physician: r this certifica ral director, p	To B	examiner? 1 Yes 2 X No	Hospital:	nt 2 🖾 ER/O	utpatient	: 3□ DOA Oth	or				Other (Specify	/1
Division of	nding Ph tth. :: After thi e funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day	y 28b.	Time of Injury	28c. Injur Wor		286	d. Describe ho			7
Divis	el or Attences after death	Certification;	3 Suicide 6 Could not be determined		ry - At home, fa . (Specify)	arm, stre	eet, factory, office		28	Location (St. City or Town	reet and N , State)	lumber or Rura	l Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier 1 ☑ Certifying Ph (Check only one) 2 ☐ Medical Exer	nysician: To the best of niner: On the basis of and manner state	examination at	e, death	occurred at the tir estigation, in my o	ne, date a pinion, de	nd place, and ath occurred	d due to the ca at the time, da	iuse(s) an ate and pla	d manner as st ace, and due to	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier				29c. Licens	e number		25	d. Date s	igned (Month,	Dey, Year)
	5		> YUA	MO			D52	481			Febr	uary 1,	2004
			30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type, f	Print)					J - 3	
			David Plotkin M.I	). 18111 Pr	ince P	hili	p Drive,	Suit	te 304	, Olney	, MD	20832	
	Sta Registr	-	31. Date filed (Month, Day, Year) FEB 0 4 20		r's Signature	6	Sporks	1					

State of Maryland / Department of Health and Mental Hygiene 2004 05018 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** KATHRYNE GREGORY JANUARY 16, 2004 7:20P. /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SUBURBAN HOSPITAL Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Apr. 29, 1910 9. Birthplece (State or Foreign Country) Floyd, Virginia 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Director 228-10-3448 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after deeth with the Maryla of Health and Mental Hygiene 1 Item 27 is marked other then "natural", or Iteme 23a or 28a-1 show other traumatic event, Item Modical Examinations. 1 ☐ Yes 2 ☐ No Director Maryland | Prince George's Beltsville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 13021 Elkridge Street 20705 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 27 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) 10 Administrative work private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 1s marked eny injury or other traumatic events. Ernest Eden Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A. Preston Gregroy, Jr. -son 4505 Clearbrook Lane Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Cemetery Jan. 22, 2004 Christiansburg, Virginia 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 6 Bagwaro 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nelloug **Physician** /Medical libral Bloom Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of) Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of defivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes Z⊠No 9 ☐ Unknown o 9 Unknown 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Medical Certification: To Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy of Vital completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 37 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Nnpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jan. 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bakshi Gita, M.D. 9406 Old Georgetown Rd Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) FEB 06 2004 32. Registrar's Signature State Registrar acks

	_	For State Registrar		State o	i Maryla	and / L	epart Certif	ment of	Health ar of Death			g. No.	2004	0501
Physicia /Medica	ın al	1. Decedent's Name (First, Mic	PAL	11		HLC		JA	2.	Fe	BRUARY	Day	1,20004	
Examine		4a. Facility Name (If not institute HOLY CROSS  5. Social Security Number		PIAL	mber) 7. Age (In y	rs. last birt	hday) _li	SILVO Under 1 Ye		VG 4 Hrs. 8.	Date of Birth	Mo	ounty of Death  ONTGON  9. Birth	blace (State or Foreigntry)
Funeral Director		577-16-7716 Usual Residence of Decedent	1 🔯 1	M 2□F	8:	3 `	Yrs.	onths Da	ys Hours	Min. D	(Month, Day, Dec. 11	, 192	20 Wash	ington, D
f show	ō	10a. State 10b. Cour	•			City, Town								10d. Inside City Limit 1 ☐ Yes 2 🛣 N
a or 28a-	Directo	Maryland Mont 10e. Street and Number 3310 N. Leist	gomer					10f. Zip Cod			10	g. Citizer US	n of What Cou	ntry?
	by Funeral	11. Marital Status  1 Never Married 2 Nover Ma	arried 12		edent Ever in proes? 2   No				of Hispanic Origi Juban, Mexican,	in? (Specif Puerto Ric	y Yes or No- an, etc.)	14.	Race - Ameri Black, White, Decify: Wh1	etc.
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other ant, I	Be	17. Father's Name (First, Midd					Gene	Lar o	18. Mother	's Name (F	First, Middle, M	aiden Su		LOII
and Mental I	ဥ	Harry P. G.			c •	19b	Mailing A	Address (Str	Plan eet and Number		ite Car Route Number,		own, State, Zij	o Code)
parmir rages I aru z sinoulu zo Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic en		Edith L. Gall  20a. Method of Disposition  1 🖾 Burial 2 □ Crematic  4 □ Donation 5 □ Other	n 3∐Re		_	b. Place of	Disposition of the Disposition o	Leis on (Name of ory or other Natio netery	place) nal F	ld B1 Date ebrua 2004	ry 12	Oc. Local	tion - City or T	ring, MD 209 own, State Virginia
Departm Importa any inju		21. Signature of Funeral Servi	ce Licensee	L-Co	le		Fra	ame and Ad	dress of Facility	ins Fu Blvd.	uneral	Home	Inc.	g, M D 209
ysician Medical		23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	or complic ist only one a.	ations that cause on	caused the deach line.	leath. Dor	ot enter t	he mode of	dying, such as c	ardiac or re	espiratory arre	st,		Approximate Interval Between Onset and Death
xaminer	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<ul><li>b.</li><li>c.</li><li>d.</li></ul>	Due to Due to	(or as a cons	= GA	ot): STICIC	.53	SULVI) IN	v6				IWK
	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23	1 Live	itcome of pre birth 2   F nant at time	etal death		topic pregnather (specify				230	1. Date of deliv Month	ery Day Year
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i Dir	Certification;	3 ☐ Suicide 6 ☐ Co	ld not be ermined	28e. Plac	e of Injury - A ling, etc. (Sp	At home, fa	ırm, street	, factory, off	ice	286	f. Location (Str City or Town		lumber or Rur	al Route Number,
hin 24 hours a tha Funaral I npletely filled	edical C	29a. Certifier 1 Certi (Check only 2 Medi	ying Phys el Examin	er: On the I	e best of my basis of exan	knowledge nination an	e, death o	ccurred at the	e time, date and ny opinion, death	d place, and h occurred	d due to the ca at the time, da	use(s) an te and pl	id manner as s ace, and due t	stated. o the cause(s)
within To the comple	Me	29b. Signature and title of cer	fier Clin				-	29c. Lio	62.52		75 FE	d. Date s	igned (Month,	Day, Year) 5,2004
		30. Name and address of pers	on who con	mpleted cau	use of death (	(Item 23a)	Type, Pri	nt) 1A-A	VE#51	15 W	HENTOI	VM	D 209	5,2004
Sta		31. Date filed (Month, Day, Yo	ar)	32.	Registrar's S		4	Some					-	

State of Maryland / Department of Health and Mental Hygiene 2 104 05020 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Albert Alexander Gough February 2004 1:15 A M /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 420 Coster Road Calvert Lusby | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 25, 1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 216-16-4665 Yrs Marÿland 78 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County IT is marked other than "natural", or Items 23e or 28e-1 show traumatic event, it is Medical Examinating that the notified at 1 ☐ Yes 2 ♥☐ No Maryland Calvert Director Lusby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 420 Coster Road 20657 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours atter to Department of Health and Mental Hygiene. International streets of the 27 is merked other than "natural", or Item any injury or other traumatic event, the Medical Examinat OREs. 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 X Married 1 Yes 2 No Specify Black Baltimore, Maryland 21215-0036 Specify: þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Warehouseman Naval Base 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Parran Gough Emily Jane 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lusby, MD 20657 Virginia Gough/wife 420 Coster Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Holland Cemetery  $\frac{12}{5}/2004$ Huntingtown, MD 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 21. Signature of Funeral Service Licensee Mady a. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 6 se anoma **Physician** (0 /Medical resulting in death) Due to (or as a consequence of): Examiner WITH Ven Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760. ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Partil: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should be 1 Yes 2 No 3 Probably 4 Inknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 ☐ Yes 2 🕶 o 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Sesidence 6 Other (Specify) Certification: To 1 🗌 Yes RZNO this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Accider 5 Pending death. 1 ☐ Yes 2 ☐ No Accident investigation after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 | Homicide within 24 hours a To the Funerel L Hospitel 1. X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29c. License number 29d. Date signed (Month, Pay, Year, 29b. Signature and title of certifier C Alla Jety zic 30. Name and address of person who completed case of death (nem 23a) (Type, Print) M.D. Anwar Munshi, Prince Frederick, MD 20678 6 31. Date filed (Month, Day, Year) 32. Registras Signature State 2004 Blacus. 1 FEB 04 Registrar

			1 - For State Registrar	State o	f Marylar	nd / Depa <i>Cei</i>	artment of H	ealth and Death		giene2 (	004	05021
			Decedent's Name (First, Middle	, Last)					2. Date of De	ath		3. Time of Death
	Physicia		Thelma	Elain	е		Greene		Januar	y 31, 2	Year 2004	3:20 P M
	/Medic Examin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town, or	Location of Dea			ty of Death	
		•	15284 Poplar Hi	ll Road			Malcolm			Char	les	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs		rth	9. Birth	place (State or Foreign
	Director		217-60-5464	1 ☐ M 2 <b>X</b> ☐ F	51	Yrs.	Months Days	Hours Mill	March	21, 1952	Wash	ington, DC
	<u>و</u>		Usual Residence of Decedent		140-0	-						
	show	_	10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation					10d. Inside City Limits
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	ith th	<u>Dire</u>	10e. Street and Number				10f. Zip Code			10g. Citizen d	f What Cou	untry?
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	tems	Funeral	11. Marital Status	Armed Fo			Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (: .n, Mexican, Pue	Specify Yes or No nto Rican, etc.)		ace - Amer ack, White	ican Indian, , etc.
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Maryland	d be antal ced o	o Be	Alfred	Johnso	on			Dorothy				Johnson
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Σ	- E N =		Dorothy	Johnson/	Mother		Poplar H			. ,		·
ē,	- I 6 =		20a. Method of Disposition	DOI II ISOIT/	20ь.	Place of Dispo	sition (Name of	!	Date	20c. Location		
٥			1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S				matory or other place tion Ceme		5/04	Clinto	n. Ma	ryland
Baitimore,	permil. Page Department Important: If any injury o		21. Signature of Funeral Service				2. Name and Addres		,, 01	CIIIICO	11, 110	I y I di la
g	pen tmp any		Odessa O		MO13	1	dams Fune		P.A. Ad	quasco,	Mary	land
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on e	caused the dea	th. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between
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Ď,	le be executed /sician and e burial-transit		resoluting in death) Last	Due to	(or as a conse	quence of):						
8/60	cate be executed physician and the burial-transit	dical		d				-				
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X P P	death certifi e attending I d for use as	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	tcome of pregn pirth 2 ☐ Fet	al death 3	Ectopic pregnancy				ate of deliv	very Day Year
_	at the de by the a stached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9☐ Unkn	nant at time of own	death 5	Other (specify)					
<u>.</u>	that the ed by detac		Part II. Other significant condition	ons contributing to d	eath but not re-	sulting in the u	nderlying cause give	on in Part I	23e Did I	tobacco use co	ntribute to	the cause of death?
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<u> </u>	icien: Th certificate rector. pag	Be	25. Was case referred to medica examiner?	Hospital:			othe Othe	25	ath (Check only			
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5	ding After fune	ion	1 Natural 5 ☐ Pendir	g (Mon	th, Day Year)	Injury	Worl	(? Yes 2 □ No	Zod. Describe	now injury occ	med	
<u>s</u>	death death stor: / the	cal	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be One Bloom	of Injury - At h	some farm et	reet, factory, office	.63 2 110	28f Location /	Street and Nur	nher or Rui	ral Route Number,
Division of	or Attend after death Director: /	Certification:	4 Homicide determ	build	ing, etc. (Speci	ify)	cot, lactory, office		City or To	wn, State)		ar riodio repingor,
	Hospital		29a. Certifier Certifyii	ng Physician: To the	best of my kn	owiedge, deat	h occurred at the tim	ne, date and place	e, and due to the	cause(s) and r	nanner as	stated.
	I 4 II 0	ledical	(Check only 2 Medical one)	Examiner: On the b	asis of examin	ation and/or in	vestigation, in my or	oinion, death occ	urred at the time,	date and place	, and due	to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certife		/		29c. License	number		29d. Date sig	red (Month	, Day, Year)
			) Xx. [	Lehn	W		D	20552		2/2	104	
(			30. Name and address of person	who completed caus	se of death (Ite	m 23a) (Type,			<u> </u>	1.1		
1	B		HARVEYKUTZ	en M()	841	6 Wo	estend!	d (	1. NON	MU		
	Sta		31. Date filed (Month, Day, Year,	5 2004 32.F	Registrar's Sign	ature	South s		7			
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		•	1 = For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment rtificate	of H	ealth a Death	and M	ental Hyg	iene g. No.	004	05022
	Physici		Decedent's Name (First, Middle, Last  Evelyn Virginia							2. Date of Dea Month	Day	Year 2004	3. Time of Death 4:43 PM
	/Medic Examin		4a. Fecility Name (If not institution, give		nr)	4b. City, 1	Town, or	Location o		7	1	ty of Deeth	
			Washington Count				erst						n County
	Funeral Director		5. Social Security Number 6. S 213–24–7586	ex	Age (In yrs. last birthday 74 Yrs.	Months	Days	If Under: Hours	Min.	8. Date of Birth (Month Day OCT 29,	1 <sup>9</sup> 29	Coun	ace (State or Foreign try) 1 land
	D		Usual Residence of Decedent		10c. City, Town or L	conting							0d. Inside City Limits
	Manylau f show	or	Maryland Washing	ton	Hagers								Yes 2 No
	or 28a	Irec	10e. Street and Number			10f. Zip				1	0g. Citizen o		try?
	ath wit	ralD	319 Radcliffe Av				1740			7	U.S.A	ace - America	an Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f show any njury or other traumatic event, the Medical Examinating must be notified at ODG.	by Funeral Director	Never Married 2 Married     Widowed 4 Divorced	12. Was Deceder Armed Force 1 Tyes 24 If Yes, Give Year or Dates	PNo	Was Decedor If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto f	cify Yes or No- Rican, etc.)	ВІ	ace - Amend lack, White, e hify: Whit	etc.
215-0036	72 hounders	eted	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Giv	edent's Usua e kind of wor	k done o	tu <i>ring</i> most	t of workin	ng	16b. Kind of	Business/Inc	Justry
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/lan	should be filed within ind Mental Hygiene. I marked other than "umatic event, the Mas	To Be	John Thompson							. Redmo			
Maryland	12 sho h and l 7 Is ma trauma		19a. Informant's Name/Relationship ( Pamela Rae Grubb							Route Number boro, F			
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OE.	Pages nent of ant: If it		1 Burial 2 Cremation 3 C 1 4 Donation 5 Other (Specif		Rose Hill	L Ceme	tery	7   J		28, 200		-	own, Maryla
Baltimore	permit. Departm Importa any inju		21. Signature of Funeral Service Lices	1500									ral Home Land 21742
	Physician /Medical	C	23a. Pert1. Enter the discusse, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caus one cause on each a.	ine.					r respiratory arr			Approximate Interval Between Oaset and Death
8	Examiner		Comment in the state of the sta	EM	HUSEM	9							YEARS
760,	eath certificate be executed attending physician and for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequence of):	Elli	TV_	۲					YEARS
9	certificate iding phy use as the		IF FEMALE:	· ·									
O. Box	0 0	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No		n 2 ☐ Fetal death 3 tat time of death 5	□Ectopic pre						Date of delive Month	Day Year
٥	sign sign	ed by Ph	Part II. Other significant conditions of CHRM			underlying ca	Suse give	en in Part I		23e. Did to	/		ne cause of death? ably 4 □Unknown
Il Records,	The law ate has b page 2 sl	Complet								24a. Was a autop perfor 1 Yes	sy	prior to cor death?	psy findings available inpletion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	25 5 D/O 12 12 1		Oth	oc		n (Check only or me 5 ☐ Resid		Whos /Coople	
of	ding I. After fune		1 Yes 2 No  27. Manner of Death 1 Watural 5 Pending 2 Accident investigation	28a. Date of I (Month,	atient 2 ER/Outpati- njury 28b. Time Day Year) Injury	-	8c. Injun Worl	4 🔾 140	1	28d. Describe h			9
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 4 Homicide 6 Could not be determined	e 28e. Place of	Injury - At home, farm, s etc. (Specify)	treet, factory	, office			28f. Location (S City or Tow	treet and Nur n, State)	mber or Rura	I Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical C	29a. Certifier (Check only one)  1 Certifying Plants one)  1 Certifying Plants one)	nysician: To the be miner: On the bas and manne	ast of my knowledge, dea s of examination and/or stated.	ath occurred investigation,	at the tin	ne, date an pinion, dea	d place, a	and due to the d ed at the time, o	ause(s) and r date and place	manner as st e, and due to	ated. the cause(s)
	Toth within	Me	29b. Signature and little of certifier	15	Nousie	290	Λ	o number	204		29d. Date sign	Ted (Month,	Day, Year)
	H		30. Name and address of person who	completed chuse	of death (Item 23a) (Type	e, Print)	۸	HAC	500	THIAI	M	D	
	7` St	ate	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signature	2 (6)		ליינו	146.	1000	111		
	Regist		JAN 28 2	004 /	come to to	rocks							

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05023 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 26, <u>Anna Elizabeth Gossard</u> 2004 3:35 JANUARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON COUNTY HAGERSTOWN RAVENWOOD LUTHERAN VILLAGE 9. Birthplace (State or Foreign Country) 1911 Maryland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2X F 92 November Director 213-18-9781 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at Hagerstown Washington 1 Yes 2 No Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21740 1183 Luther Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 Ho Specify Baltimore, Maryland 21215-0036 Completed by 3XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than Board of Education Teacher 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental h Mary Feigley John Paul Richard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum 404 E. Magnolia Ave. Hagerstown, Maryland 21742 Virginia Ann Gossard/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. 2, 04 | Hagerstown, Maryland 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Fastern Blvd. N. Hagerstown, Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Olz heim Due to (or as a consequence of): 8 years heim Discare **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Physiclan/Medlcal use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ After this certificate has been signifuneral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 2 No 1 ☐ Yes Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide filled in by 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-26 D28365

141 State Registrar

Elizabeth

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GOSSARD,

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A n 2

32. Registrar Signature

State of Maryland / Department of Health and Mental Hygiene 2004

05024 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Feb 2004 Helen L. Gillespie 3:50 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Nursing Home Cumberland Allegany If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Aug 5, 1906 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2√2 F Yrs 211-18-1441 97 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "netural" or linear any Injury or other trainment. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No Director Allegany Cumberland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 512 Winifred Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sherman Amick Harriet Fisher 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 403 E. Penn St., Bedford, PA Mrs. Jean Wingard-Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb 5, 1 DBurial 2 ☐ Cremation 3 ☐ Removal from State Bedford Cemetery 4 Donation 5 Dother (Specify) Bedford, PA 2004 21. Signature of Funeral Seg 22. Name and Address of Facility e Licensee Hafer Funeral Service, PA 1302 National Hwy, LaVale, 21502 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** vasalar accident /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner or Attending Physician: The law requires that the death certificate be executed physician end s the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) attending p signed by the a d be detached f Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s certificate 1 TYAS 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred After ospital c.
4 hours efter dear.
-rel Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No (2 | Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital 24 hours Medicai Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fi (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 30. Name and address of person n Rs 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 04 2004 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2004 05025 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 6.47 M JARRER **Physician** FEBRUARY 05 2004 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner TOSD MORE If Under 24 Hrs. rital Johns 144 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 Ϊ M 2 🗆 F 57 Sept 1946 Pennsylvania Director 198-34-7348 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral, or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Pennsylvania Barto Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 19504 United States 373 Hoffmansville Road death Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: à White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Owner/Operator Restaurant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Evelyn Shaner Charles Garber, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Garber/Wife 373 Hoffmansville Road, Barto, Pennsylvania 19504 20b. Place of Disposition (Name of cometery, crematory or ether place).
LIMETICK Garden of Date 20c. Location - City or Town, Stete 20a. Method of Disposition February 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11, 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Limerick, Pennsylvania Memories 21. Signature of Funeral Service Licenses 22. Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MASTROINTESTINA ONE WEEK resulting in death) /Medical Due to (or as a consequence of): Examiner ONE YEAR IVER DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed д 2 No 3 Probably 1 🗌 Yes 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an has page 2 2 No certificate 1 ☐ Yes 2. No Attanding Physiclan: director, 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Inpatient 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Yes this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 10 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier LES-000 TEBRUARY 05, 2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOO WORN WOLEZ STREET BALTHURE MARYLAND 21287 , MD 32. Registrar's Signature 31. Date filed (Month State Registrar

DUS 04-00701 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Wayne L. Hadrick 05026 1- State poended Item#23a,27, Per ME, G828,2/20/ Gentificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 25 2004 Hadrick Wayne Lamont 337 а м January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot. Easton 21 S. Hanson Street If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 215-94-2026 Director 24 Jan 11,1980 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f ahow traumatic avant, the Macical Examiner must be multial at 1 DeYes 2 No Director Talbot Easton Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 115 Hanson Street 21601 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Btack, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or iten any injury or other traumatic avant, the Medical Exami 1 Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jonathan Wayne Hadrick 2 Rowenia Darnia Potter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Valerie Potter/ Aunt 1070 N. Washington Street, Easton, Maryland 21601 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removat from State \* 4 ☐ Donation 5 ☐ Other (Specify) Richards Cemetery 01/31/2004 Easton, Maryland 21. Signature of Funeral Service Lice See Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat **Physician** Complications of Congenital Heart Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, tF FEMALE: 23c. tf yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) ☐Yes 2☐No detached 9□ Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

↑☑ Yes 2☐ No 24a. Was an this certificate has autopsy performed? 1 Yes 2 No neral Director: After this certific filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 2Other (Specify) at scene 1 Nes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1X Naturat 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō within 24 hours a To the Funeral L 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year January 26 2004 OCME Lausher

State Registrar 31. Date filed (Month, Day, Year)

JAN 3 0 2004

lasha

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

reenberg

32 Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 L For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year TAWVAKY 29 2004 HAZEL CLARICE HAMMOND 8:59 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES Doctor's Community Hospital Lanham If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 23, 1927 6. Sex 5. Social Security Number Days Hours 1 M 20 F 77 Maryland 214-28-3833 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes ¾☐ No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15801 Radwick Lane 20906 U.S.A. 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Engineer Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William H. Adams Bertha Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 9 0 6 19a. Informant's Name/Relationship (Type, Print) 14939 Ladymeade Cir., Silver Spring, MD Wendy H. Johnson (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ash\_Memorial Cem 2/4/04 Sandy Spring, MD 4 Doriation 5 Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. Signature of Funeral Service Lice 1 246 N. Wash. St., Rockville, MD 20850 Tart1. Enter the disease, or complications that caused the left. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ne in failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sles con L sionely Due to (or as a consequence of): b.trs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 patient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 ☐ Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide (Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Physician

/Medical

**Examiner** 

**Funeral** 

Director

ns 23a or 28a-f show

or Items

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Interestant: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examples any injury or other traumatic event.

Physician

/Medical

Examiner

attending physician and

the

The law requires that the death certificate be executed

To the Hospital or Attanding Physician:

Director: After

within 24 hours a To the Funaral D

Division of Vital Records, P.O. Box 68760,

Examine

Be Completed by Physician/Medical

Certification: To

Medical

Baltimore, Maryland 21215-0036

Director

þ

Completed

with the Maryland

death

31. Date filed (Month, Day, Year) FEB 04 2004 32. Registrar's Signature

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		State of Maryland / Department	artment of Health and M rtificate of Death	lental Hygier	ne 2004	05028
		Registrar  1. Decedent's Name (First, Middle, Last)	tillouto oi Douil	2. Date of Death		3. Time of Death
Physici		BERNARD EUGENE HARVEY		JAN 2	Day Yeer 2 2004	4:35 P M
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deeth	
ZX		NATIONAL NAVAL MEDICAL CENTER	BETHESDA		MONTGOME	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	II Under 1 Year   II Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Sirth (Month, Day, Ye		ace (State or Foreign try)
Director		223 /4 0//1 33		07/13/1	950 New M	<u>exico</u>
and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation		10	d. Inside City Limits
Maryl 4 she	Ď	VA Fairfax Springfie	eld			1 ☐ Yes 2 ☑ No
the 28s	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?
h with		7704 Wagon Trail Lane	22153	1	USA	
d within 72 hours after death with the Maryland liene. I than "naturel", or Items 23a or 28a-f show It a Madical Exertire chart be notified at	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Spell Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
or it	y Fu	1 Never Married 2 Married 1 Married	1 ☐ Yes 2 No Specify:		Specify: Wh	ite
urei',	d by	3 Widowed 4 Divorced Page or Dates: 2000	edent's Usual Occupation	166	. Kind of Business/Ind	lustry
"nat	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired)		, Mile of Businessame	ostry .
filed within 7 Hygiene. other than "r ent, Ire Med	mo	Elementary/Secondary (0-12)  College (1-4or 5+)  5+  Progra	am Manager	D	efense	
at the	0	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	den Sumame)	
	To B	Bernard Elmer Harvey	Violet J	oanne Gib	son	
2 should and Men is marke surnatic		, , , , ,	ing Address (Street and Number or Rura			
of Health and Ment of Health and Ment I Item 27 is marked r other traumatic			Wagon Trail Ln. S			
Pages 1 nent of He nnt: If Iter		20a. Method of Disposition  20b. Place of Disposered Place of Disp	matory or other place)		. Location - City or To	
Iment tant:					lington, V	
permit. Pages Department of I Important: If It sny injury or o		/ (/ 🗅 l ) // /	2. Name and Address of Facility Ad 211 Lee Highway Fa			
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   MASSIVE CEREBI Due to (or as a consequence of):	ROVASCULAR ACCIDEN			Approximate Interval Between Onset and Death
i 8.	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	OTID ARTERY DISSEC	TION		
cate be executed oblysician and the burial-transit	dical Examiner	that initiated events resulting in death) Last c. FALL Due to (or as a consequence of):				
ertificate ding phys se as the		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date ol delive	B/
The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Me	230. Was decedent pregnant 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			Day Year
juires that the signed by and be detacted.	by	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to th 2 XNo 3 ☐ Prob	
fhe law requir te has been si age 2 should l	Completed			24a. Was an autopsy performed	prior to cor death?	osy findings available appletion of cause of 2 No
Physiclan: r this certifica ral director, p	BeC	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)		
ysic ous ce direc	10	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatien	ent 3 DOA Other; 4 Nursing Ho	ome 5 Residence	e 6 Other (Specify	)
ng Pt Iter th neral		27. Manner of Death 1 □ Natural 5 □ Pending (Month, Day Year) 28b. Time (Month, Day Year)	Work?	28d. Describe how i	injury occurred	
Attending r death. ector; Afte by the fune	catl	2 Accident investigation NOV 4 2003 1	2:00 noon Yes 2 No		FF CURB	10
or Att after d Direct in by I	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	it and Number or Rura State) 1777 N	N.Kent Sti
urs at urs at urai D	S	OUTSIDE OFFICE		ROSSLYN VA	,	at a d
Hospital 24 hours 2 Funeral 1 (ely filled	edical	9a. Certifier Certifying Physicis. To the best of my knowledge, dea Check only Check only Medical Examiner: On the best of examination and/or in the best of examination and the best of examination	th occurred at the time, date and place, nvestigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
the the	Med	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
		Man K Ma X - IM OME	1200428	一十	n- 30	Jan-1
20		20 Miles of a control of death (New 202) (Time	Print 2121	00	16 10	700/
		30. Name and address of person who completed cause of death (Item 23a) (Type	Silver	mi	2000	
S	ate				0,00	
St Regist	ate trar		Sporks			

State of Maryland / Department of Health and Mental Hygiene 2004 05029 State
Registra MEND#18perINF2/12/04, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY TANK **Physician** HELFSTEIN FLORENCE 31,2006 0345PM /Medical 4a. Facility Name (If not institution, give street and number, Ac. County of Deeth 4b. City, Town, or Location of Death Examiner SHADY GROVE NURSING HOME ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕅 F Months Days Hours Min 79 Yrs. Director 219-16-6987 DEC. 16, 1924 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. Count 10d. Inside City Limits 28a-1 shov the Medical Examiner must be notitied at 1 ☐ Yes 2 N No Directo MARYLAND MONTGOMERY GERMANTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 items 23a 20874 U.S.A. 13428 WINTERSPOON LANE Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No ۵ 3 ₩ Widowed 4 Divorced Specify: WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION 12 SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy
important: If item 27 is marked oth
eny injury or othar traumatic event Be JACOB OBCAS ပ္ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13428 WINTERSPOON LANE, GERMANTOWN, MD 20874 MICHAEL HELFSTEIN/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ∑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 02/02/2004 BALTIMORE, MARYLAND ROSEDALE CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
PANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 that 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) YMPHOMA - BRAIN **Physician** MEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. the attending physicien Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 5 Other (specify) detached 9 Unknown 9 Unknown ģ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this s after death.
I Director: After this
id in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C filled 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies Medical (Chạck only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOAD # 208 ROCKVILLE MD ZO 850 YASSI MUD 15228 SHADY GROVE 31. Date filed (Month, Dal, Year) 32. Registrar's Signature State FEB 0 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05030 Certificate of Death Reg. No 3. Time of Death 2 Date of Death Decedent's Name (First, Middle, Last) Physician HUGUELY MARGARET Ε. FEBRUARY 1, 2004 7:45 P /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5600 WISCONSIN AVENUE #1006 MONTGOMERY CHEVY CHASE tf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, JANUARY) 9. Birthplace (State or Foreign Country)
OHIO 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 23,1911 1 □ M 2 □ F 93 215.48.0191 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. tnside City Limits 10a. State 10b. County ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No CHEVY CHASE Director MD MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 5600 WISCONSIN AVENUE #1006 20815 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iter any injury or other traumatic svent, it a Medical Examination. 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: f Yes, Give Year or Dates: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MAURICE B. APPLEBY CAROLINE SEGAL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3720 CARDIFF ROAD CHEVY CHASE, MD 20815 JEFF HUGUELY/SON 20a. Method of Disposition

→ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State GLENWOOD CEMETERY 2/6/04 WASHINGTON D.C. 4 ☐ Donation 5 ☐ Øther (Specify) 22. Name and Address of Facility JOSEPH GAWLER'S SONS, INC. 21. Signature of Fune al Service Licensee lath 5130 WISCONSIN AVENUE NW WASHINGTON DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) CONGESTIVE HEART FAILURE **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year detached for 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes No 3 Probably 4 Unknown page 2 should Completed peen 24a. Was an autopsy performed? 1 ☐ Yes 2XXNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 🗌 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home XXResidence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00 30. Name and ac of person who completed cause of AGA . M.D. 5454 W e of death (ttem 23a) (Type, Print)
WISCONSIN AVENUE FRAGA, #1005 CHEVY CHASE, MD 20815 31. Date filed (Month, Day, Year) FEB 0 4 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2004

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			State of Maryland / Dep	ertificate of Death	rentai Hygie Reg	2004	05031
	Dharini		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		Charles A. Husak, Sr.		February	3, 2004	11:00P M
1	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Brighton Gardens	Rockville		Montgome	~
	Funeral Director		5. Social Security Number 6. Sex 12 M 2 F 7. Age (In yrs. last birthday 90 Yrs.	// If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, ) Nov. 29,	(ear) 9. Birth Cou	place (State or Foreign Intry) LO
	pur *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	be filed within 72 hours after deeth with the Maryland stal hygiene. Identified then "natural" or flema 23a or 28a-f ahow dother than "natural" or flema 23a or 28a-f ahow avent, the Medicial Examiner must be notified at	ō					1 ☐ Yes 2 ☑ No
	288-	Director	Maryland Montgomery Rockvill  10e. Street and Number	10f, Zip Code	100	g. Citizen of What Cou	intry?
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	me 2	era		. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		Inited Stat	ican Indian,
9	or ite	Ē	1 Never Married 2 Married 1 X Yes 2 No		Rican, etc.)	Black, White	, etc.
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an	d be antal	o Be					
<u>-</u>	Should Me Me mark	70	Frank J. Husak  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	L1111an ling Addrass (Street and Number or Rura	Vondrak	City or Town, State, Zi	n Code)
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Baltimore,	them of Hear		20a. Method of Disposition 20b. Place of Disp	osition (Name of ematory or other place)  February	Date 20	c. Location - City or T	own, State
Ë	Page III		1 ☐ Burial 2 MCremation 3 ☐ Removal from State  *4 ☐ Donation 5 ☐ Other (Specify)  Cremator	ry ium, Inc. 6, 20		ethesda, M	arvland
alti	mit. Partir Ports y Inju		21. Signature of Funeral Service Licensee	22. Name and Addrass of Facility Rob	ert_A. Pi	umphrey Fu	neral Home/
Ω.	20 E 2 8		MO0803 E	22. Name and Addrass of Facility Rob bethesda-Chevy Chas bethesda, Maryland	e, Inc. 20814-3	/55/ Wisco 501	nsın Avenue
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. Arteriosclerotic	Heart Disease		-	Onset and Death Years
4	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	110010 010000			10015
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	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury				
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ŏ	leath certifica attending ph i for use as th	N/UE	IF FEMALE:  23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	ery
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orc	w require been si should I	ted	Coronary Artery Disease		1 L Yes	2 No 3 Prot	Dably 4 MUNKNOWN
Records,	e law has b	Completed	Acute Renal Failure		24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
al F	Th ate pag		Atrial Fibrillation		performe 1 ☐ Yes 2 ☐		2 No
Vital		Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death			
of		. To	27. Manner of Death 28a. Date of Injury 28b. Time 6	INT 3 DOA 4 Nursing Hol	ne 5  Residence 28d. Describe how	injury occurred	(y)
O	ding f th. After funer	tlor	1 X Natural 5 □ Pending (Month, Ďaý Year) Injury 2 □ Accident investigation	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No		,,	
Division	or Attanding after death. Diractor: After	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si	treet, factory, office	28f. Location (Stree	et and Number or Rura	al Route Number,
Ö	i ii	Sert	4 Homicide determined building, etc. (Specify)		City or Town, S	State)	
	Hospitel or 24 hours afte Funeral Dir stely filled in	edical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, dea  (Check only one)  1 Certifying Physician: To the best of my knowledge, dea  2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as s and place, and due to	tated. o the cause(s)
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier	29c. Licensa number	29d.	. Date signed (Month,	Day, Year)
			in the way	D3335	7		
	1+1		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	F∈	ebruary 5,	2004
			Lee Jonathan Musher, M.D. 5530 Wisc	,	5. Chevv	Chase, MD	20815
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	/	- J DILL V Y	Jimbe, III	20010
	Registr	ar	FEB 0 6 2004 Shewar 19	Sparks			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 05032 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Physician 2004 02:35AM JAN /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner ARUNDEL GLEN BURNIE ANNE ARUNDEL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 1□ M 2 F 236-24-5174 Director 80 October 8,1923 West Virginia Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?? is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 394 Washington Ave. 21060 United States Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ Xo Specify: Specify: White δ 3 □XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Factory Worker <u>Venetian Blind Co.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unobtainable Eva Pearl Hare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Carpenter (Niece) 125 Glastonbury Lane Hedgesville, WV. 25427 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial ②Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) February Chesapeake Cremation Center Chester, Maryland 3,2004 22. Name and Address of Facility Adams Funeral & Memorial Care 21. Signature of Fundial Service Licensee M00982 814 Bestgate Rd. Annapolis, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) lumonia Examiner Due to (or as a consequence of): Examiner buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 ettending physician Physician/Medical Due to (or as e consequence of) for use es Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ funeral director, page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No edicai Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this Menner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Dey 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Corlifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) ausemo 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) NORTH ARUNDEL HOSPITAL GLEN BURNIE, 21061 LAIYEMO MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 2 2004 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2004 05033 = For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 24, 2004 **Physician** 6:55 p M Harrison, Sr. Tilghman Lawrence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Calvert County Nursing Center Prince Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1∑M 2□F 90 213-22-1226 Sept. 13, 1913 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or Items 23s or 28s-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Prince Frederick Director Maryland Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20678 85 Hospital Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. iges 1 and 2 should be filed within 72 hours after it of Health and Mental Hygiene.
If item 27 is marked other then "natural", or Ite or other traumatic avant, the Medical Exemina 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: white δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) transportation 12 proprietor trucking company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Moreland Mary Rufus Dolly Harrison 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 59, White Plains, MD 20695 Lawrence T. Harrison, Jr., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. So. Memorial Gardens Jan. 28,2004 Dunkirk, MD 22. Name and Addrass of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A., Owings, MD 20736 William 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septecemon Physician - urosepsis /Medical Due to (or as a consequence of): **Examiner** Pyelinephnitts Acute/chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ x 3 recurrences 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed - Bilateral Cerebro-24b. Were autopsy findings available prior to completion of cause of death? Cerebrovascular Insufficience page 2 s has Vascular accordents autopsy performed? certificate 1 Yes 2 No tentascherosts Diabetes Mellitus-1 1 ☐ Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 1 ☐ Yes 2 No 1 🗌 Inpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the h 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified D17245 P. Sterner mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Calvert - Arundel Medical Center, Owings, MD 20736 10 M.D. Gerald P. Sterner, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 29 Registrar

			For State Registrar	State of Ma	aryland	d / Depa <i>Cei</i>	artment of F	lealth a Death	and Me		iene •g. No.		05034
			Decedent's Name (First, Middle, La	st)						2. Date of Deat	th		3. Time of Death
	Physici /Medic	_	Catherine	Mary	Ham	pshi	re		J	January	28,	2004	12:52 a M
	Examin		4a. Facility Name (If not institution, given	e street and number)	-		4b. City, Town, o	r Location o	of Death			County of Death	
			Calvert County N	ursing Cent	ter		Prince	Frede	rick			Calver	t
	Funeral			Sex 7. Age 1 □ M 2 🖾 F		ast birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs.	8. Date of Birth (Month, Dey,	Year)	9. Birth	clace (State or Foreign ntry) ISYLVania
	Director		194-09-8809		91	Yrs.			A	pril	4,1	912 Penr	sýlvania _
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Aaryli I sho	ō		_	_		ederick						1 ☐ Yes 2 ☑ No
	the N	Director	Maryland Calvert		F1.1	iice iii	10f. Zip Code			1	0g Citi	zen of What Cou	
	death with the Maryland rms 23e or 28a-f show	ă	85 Hospital Ro	oad				678		'		.S.A.	
	leath	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S	6. 13.	Was Decedent of H	lispanic Orio	gin? (Spec	ofy Yes or No-		14. Race - Ameri	can Indian,
_	r then	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give 2	lo	,	TYES, SPECITY CUD	an, mexican	, Puerto R	tican, etc.)		Black, White,	
0000	urs a	by	3 Widowed 4 Divorced	If Yes, Give A: Year or Dates:			1□Yes 2∏ No	Specify:				Specify: whi	.te
5	within 72 hours after ene. than "natural", or ite he Medical Examine	ted	15. Decedent's E (Specify only highest gr	ducation			dent's Usual Occup		of working	0	16b. Ki	nd of Business/Ir	dustry
7	thin the control of t	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use retired	d)	O HOINI	9			
7	ygien ygien her th t, the	Completed	12			Edito	rial cle						riculture
2	tal H d off	Be	17. Father's Name (First, Middle, Last		2					(First, Middle, M		•	
<u> </u>	ould Men Marke	မ	Samuel		ord				nerin		rian		
10	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than " Iraumatic event, the Mau		19a. Informant's Name/Relationship	•			ng Address (Street						
e,	s 1 and 2 should be filed within 72 hours after death with the Marylar of Hema 23 marked all hygiene at 1884-1 show them 27 is marked other than "natural", or flems 23e or 288-1 show other traumatic event, the Maulical Examiner minatic to nutified at		Robert R. Hampsh:	re, son	20b. Pl		Brookevio	ew Ct.	., Ch			each, ML cation - City or To	
2	ages or or or	1	1 Burial 2 ☐ Cremation 3		Ce	metery, crer	natory or other place rial Garde	ens   ens   1	1/31/			kirk, M	
Saltimor	it. Paurtment intant injury		* 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice				. Name and Addre				Jui	reality in	
מ	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		> William +	3. Ler	-		usch Fun		•	P.A.,	Owi	ngs, MD	20736
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	one cause on each lin	Θ.						est,		Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	a Conc	rest	tue.	Heart	Fail	ure				Days
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):							
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a			Correlio	varei	reas	DIZEN	8€		years
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury	545 (5) 45 2	2 00110042	01100 01).							
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00/9	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dicat	· ·	d									
00	ificati g phy as the	edic									109		
XO2	n certific anding pl use as t	M/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnancy				2	3d. Date of delive	ery
ם	deat le atte	icla	in the past 12 months? 1 □ Yes 2 🗷 No	4☐Pregnant at			Other (specify)					Month	Day Year
)	at the by the	Physician/Me	9 Unknown			- 600							
ń	gnec be d		Chrenic Brenchis	-			nderlying cause giv						ne cause of death?
necords,	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	Completed by				umo	nary Di	SOASR		1 🗆 Ye	is 24	Z-No 3   Prot	pably 4 Unknown
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5	Phys this ral dir	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatier		R/Outpatien 28b. Time of	t 3 DOA 28c. Injur	4 CACAGO		e 5 🗌 Reside 3d. Describe ho		Other (Specif	y)
	ding h. After fune	tlon	1 (SNatural 5 ☐ Pending	(Month, Day	Year)	Injury	Wor	k?" Yes 2∐N		5d. <b>5</b> 0301150 110	** inqui	00041194	
Vision	Atten deat ctor: y the	flca	3 Suicide 6 Could not b	28e. Place of Inju	ıry - At hor	ne, farm, str						d Number or Rura	I Route Number,
5	after after Dire	Certification:	4 Homicide	building, etc	: (Specity)	)	•			City or Town	, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death, within 24 hours after death. To the Funeral Director Attenthis certificate has completely filled in by the funeral director, page 2.	edical C	(Check only 2 Medical Exe	hysician: To the best of miner: On the basis of	examinati	vledge, death on and/or in	n occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, an	nd due to the ca	use(s)	and manner as s	tated.
	thin 2 the the mplet	Med	one) 29b. Signature and title of certifier	and manner sta	IĐO.		29c. Licens	e number		20	d. Date	signed (Month,	Dev. Year)
	8 7 ¥ 7		· Constal	P. Stern	٠ ـ ـ ٥	Μ.Λ		172	4 -	-	The same of		18, 2004
			30. Name and address of person who			23a) (Type		1/02	1 4				0,000
	6		Gerald P. Sterne				indel Medi	ical (	onto	r Ourin	ac	MD 207	26
7	Sta	te	31. Date liled (Month, Day, Year)	3. Registra	ır's Signati	ure		LCar (	CITCE.	L, OWIII	yo,	MD 207	
	Registr	ar	JAN 2 9 201		K	Bre	M.S						

		•	For Stete Registrar	State of	Maryland / [	Depa Cer	artment of H	lealth a Death	and Me	ntal Hygi	ene 20	04	05035
	· ·		1. Decedent's Name (First, Midd						2	2. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic		Larry 1	Louis	Henry					January	26, 20	04	12:20 p M
	Examin		4a. Facility Name (If not institution	. •			4b. City, Town, or				4c. County		
			Calvert Count		Center 7. Age (In yrs. last bir)	thday)	Prince				Cal		place (State or Foreign
	Funeral Director		5. Social Security Number 218-44-4790	1. M 2□F		Yrs.	Months Days	Hours	Min.	B. Date of Birth (Month, Day, pril 9,	Year) 1947	Cou	ryland
			Usual Residence of Decedent							P			1
	nylan how		10a. State 10b. County		10c. City, Town								10d. Inside City Limits
	86-18	cto	Maryland Calv	ert	Princ	e i	rederick						1 ☐ Yes 2 💢 No
	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other then "neturel", or Items 23e or 28e-f show event, The Medical Exertil arthurst be notified at	Funeral Director	10e. Street and Number 85 Hospital	Road			10f. Zip Code	20678	}	10	g. Citizen of V U.S.Z		ntry?
	eath ns 23	era	11. Marital Status		dent Ever in U.S.	13.	Was Decedent of H	ispanic Ori	igin? (Speci	ify Yes or No-	14. Race	- Ameri	can Indian,
<b>'</b> 0	r Iten	표	1 ☐ Never Married 2 🔀 Mar	Armed For	ces?		If Yes, specify Cuba	an, Mexicar	n, Puerto Ri	can, etc.)		k, White,	
93	rel', o	l by	3 ☐ Widowed 4 ☐ Divorce	If Yes, Giv Year or Da	e 21 ites:		1 □ Yes 2 1 No	Specify:			Specify	· wh:	ite
5-0	72 h	Completed	15. Deceder (Specify only higher	nt's Education est grade completed)	16a.	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during mos	t of working	, 1	6b. Kind of Bu	siness/In	dustry
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d 2	Hygi Hygi ther nt. 1		17. Father's Name (First, Middle	Last)			Darobii		er's Name (	First, Middle, M			
au	ld be ental ked c	То Ве	Edgar Boot	h Henry				Cl	.ara	Emma	Schne:	ider	
Maryland 21215-0036	s 1 and 2 should be if Health and Mental I Item 27 is marked oother treumatic eve	_	19a. Informant's Name/Relation	ship (Type, Print)			ng Address (Street						
Σ	is 1 and 2 of Health a Item 27 is other tree		Mary Ann He	nry, wife		-				-			, MD 20714
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from 5	20b. Place of cemeter	Dispo ry, crei	sition (Name of matory or other place	(9)	Da		Oc. Location -	•	
Ē	Pag ment lent: jury c		*4 □Donation 5 □ Other (	Specify)	Metrop		itan Crem	- 1		/2004 A	Lexand	rıa,	VA
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any injury or ot once.		21. Signature of Funeral Service	Ricensee			Name and Addre Susch Fun		-	P.A.,	Owings	, MD	20736
ı			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that can only one cause on ea	aused the death. Do a ach line.	not en	er the mode of dyir	ng, such as	cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
P	Physician	8 V)	Immediate Cause (Final disease or condition	_a Care	diac 1	72	chythm	214					10 minutes
	/Medical Examiner		resulting in death)		or as a consequence	of):							more than
		<u>.</u>	Securitally list conditions if any, leading to immediate	U. observations	or as a consequence	****	Grai	OVa	scula	7 di	tase		2 yauns
	nted 1 Ansit	Examine	cause. Enter Underlying Cause (Disease or injury	<b>〈</b>		-							
ć	exection and trial-tra	Exa	that initiated events resulting in death) Last	c. Due to (	or as a consequence	of):							
8760,	ate be executed obly sician and the burial-transit	dlcal		d									
9	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ved	IF FEMALE:								1		
Box	eath certific attending p for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	come of pregnancy irth 2 Petal death		Ectopic pregnancy	,			23d. Dat Mo	e of deliv nth	ery Day Year
0.	it the dea by the a tached f	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregn 9□ Unkno	ant at time of death own	5L	Other (specify) _						
Δ	that the		Part II. Other significent condit	ions contributing to de	eath but not resulting in	n the u	nderlying cause giv	en in Part I	l.	23e. Did tob	acco use conti	ibute to t	he cause of death?
ds	uires n sign lid be	d by	Anoxic en	enhalona	thy due	te	Carchia	Ar	rest	1 □ Ye	s 2 No	3 🗆 Pro	pably 4 Unknown
S	w requires been si	Completed	Hyperthyro		/					24a. Was an	24b. \	Vere auto	opsy findings available ompletion of cause of
Re	The lav	mo	- rejpectrizing	7003.07						autopsy perform	ed? c	leath?	
ital		0	25. Was case referred to medic	al				26. Place	e of Death (	Check only one			
<b>\</b>	di is	To B	examiner? 1 Yes 2 No	Hospital: 1 □ I	npatient 2 ER/Ou	ıtpatie	nt 3 DOA Oth	er: 4 Nu	ursing Hom	e 5 ☐ Resider	nce 6 Oth	er (Speci	(y)
0 0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pend	28a. Date of (Mont		Time c Injury	Wor	k?		ld. Describe how	w injury occurr	ed	
sio	death. ctor: A the fu	catl	2 Accident inves	tigation	of Injury At home for			Yes 2□	-	of Location /Str	eet and Numb	er or Dun	al Route Number,
Division of Vital Records,	or Attendate after death Director: /	Certification:	4  Homicide deter	mined 286. Place buildi	of Injury - At home, fa ng, etc. <i>(Specify)</i>	ırm, sı	reet, factory, office			City or Town,	State)	or or man	arriodio reambor,
_	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical C	29a. Certifier 1 Certify (Check only one) 2 Medice	ing Physicien: To the I Exeminer: On the ba	best of my knowledge asis of examination an ner stated.	e, deat	h occurred at the tir vestigation, in my c	ne, date ar ppinion, dea	nd place, ar ath occurred	d due to the ca I at the time, da	use(s) and ma te and place, a	nner as s and due t	stated. o the cause(s)
	Fo the vithin Fo the	Me	29b. Signature and title of certification		^		29c. Licens				d. Date signed		
	C > F 0		) - Cey	an.c	hu	a	$\mathcal{D}$	5C	653	5	1/2	7/0	34
	3		30. Name and address of perso 5851 Dea				Print) GY	AN	-C ·	54R	ANA 751		
	Sta	ate	31. Date filed (Month, Day, Yea	r) 32.	egistrar's Signature		•	2001		. 17 00			
	Regist	rar	JAN 2	2004	Dur. H	1	called						

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene WILLIAM G. HINES Reg. No. 2004 For State Registrar 05036 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** JAN. 28 2004 ear 9:11 P M William Gene Hines /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAGERSTOWN WASHINGTON COUNTY HOSPITAL WASHINGTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1፟**M** 2□ F Yrs. Director 219-66-2194 47 04/15/1956 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 XYes 2 No Director MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 333 N. Locust Street 21740 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 □ Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married ŏ 1 ☐ Yes 2 No White Specify: ģ Specify: 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10Forklift Operator Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Eugene Franklin Hines Anna Marie Raybold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna M. Nicol / Sister 12412 Emory Lane, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of P Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 01/30/2004 Smithsburg Crematorium Smithsburg, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Thrembosis -sonam /Medical Due to (or as a consequence of): Examiner cardinascular disease. Athenosclenotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-transit and Due to (or as a consequence of): physicien Physician/Medical the the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) detached þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ eq 3 Probably 4 □Unknown 1 Yes 2 No Completed phods peen 24b. Were autopsy findings available prior to completion of cause of death?

124es 2 \sum No 24a. Was an has page 2 autopsy performed certificate Yes 2 🗆 No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 X Yes 2 ☐ No 2XER/Outpatient 3□ DOA funeral dir this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire 4 Homicide To the Hospitel or filled t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E JAN. 29, 2004

State Registrar

31. Date filed (Month; Day, Year)

Loneinber

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05037 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1430 PM Ray Pentley Harper 2004 ANVERY 28th /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Washington County Washington County Hospital Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**□X**M 2□ F 65 Yrs. Director 219-36-3082 Sept. 30,1938 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "natural", or Itams 23a or 28a-f ehow the Madical Examiner must be notified at 1⊠Yes 2 No Directo Washington Maryland Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code U.S.A. 11 S. Walnut Street 21740 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bartender Self Employed permit. Pages 1 and 2 should be filled Department of Health and Mental Hygid Important: If Item 27 is marked other eny injury or other traumatic event. It 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles William Harper Mildred Loy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael R. Harper/Son 17950 Garden Lane Apt. 1 Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Jan. 31 2004 Smithsburg, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature x Fur eral Service Licens 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 Crylor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 100 1/1 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the attending physicien and thed for use as the burial transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 2 **N**O 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Ses 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. 1 Tes 2 No investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 51x.8x1 10011266 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 80 Nos Trom ML31. Date filed (Month)

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

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		•	For State Registrar	State of many tank		tificate of E			Reg. No. 2004	05038
H	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last	e Hull, S	12			2. Date of Dea Month	Day Year	3. Time of Death
	Examin		4a. Facility Name (IDnot institution, give	street and number)	_	4b. City, Town, or			4c. County of Death	h
	Funeral		5. Social Security Number 6. Se		last birthday)	If Under 1 Year		8. Date of Birth (Month, Day	Washi 9. Birth	nplace (State or Foreign
в	Director	-	220-24-2444	X <sup>M</sup> <sup>2□ F</sup> 53	Yrs.	Months Days	Hours Min.	Feb.7,1	950 West	virginia
	and w.		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Maryl. -f sho	tor	Maryland Washing	ton	Sharps	sburg				1 X Yes 2 ☐ No
	th the or 28a e rictl	irec	10e. Street and Number		•	10f. Zip Code			10g. Citizen of What Co	untry?
	ath wi	rai	214 West Chaplin				1782		US	
	ter de Items Iner n	Fune	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2000No		Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, White	
903	rel', or	by	3 ☐ Widowed 4 反 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes XX No	Specify:		Specify:	White
5-0	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-f show the Madical Examinat must be rediffed at	letec	15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occupa kind of work done de DO NOT use retired)	uring most of worl	king	16b. Kind of Business/	industry
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Maryland	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (T)						r, City or Town, State, Z	25425
	s 1 and f Health item 27 other to		Gary C. Hull, Jr. 20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of matory or other place		Date Date	t Virginia 20c. Location - City or	
E C	Pages nent of ant: If it		Bunal 2 Cremation 3 Char (Specify	removar from State		Cemetery		4,2004	Sharpsburg,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or items 23a or 28a-f ahow any injury or other traumatic svent, the Macical Examination must be notified at angle.		21. Signature of Speral Service Agens	96 / /	ල්:	sborne Adres				
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COL	> D 10	iete						24a. Was	an 24b. Were au	topsy findings available
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	n		1 / Cromes	1. Villet;	PAT 12,0	· H4	4384	-	January 3	1,2004
1	*X		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	ston Coin	ty Hespi	tal Has	E. ANTIGE erstown, M	D 21740
	Sta		31. Date filed (Month Pay Year)	32. Flegistrar's Sign	atura.	perter	1100		-1	
	Regist	rar		1001	//					

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Funeral Director		5. Social Security Number 6. Sec. 223-62-4095	7. Age (In yrs. In 59	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		945	9. Birthy SOUT	place (Stete or Foreign http:// CAROLINA			
Maryland -f ehow	tor	10a. State 10b. County  MD QUEEN A		CHURC	cation CH HILL					10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
th with the 23s or 28s	al Director	10e. Street and Number  201 ARBOR WAY			10f. Zip Code <b>21</b>	623		10g. Citize	en of What Cou	ntry?			
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27215-0036 d within 72 hours at giene. or than "natural", or the Medical Every	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed)  College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done of DO NOT use retired	during most of w	orking		of Business/In				
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C = 44 P		19a. Informant's Name/Relationship (Ty  E. MICHAEL HAMILTO			ARBOR WA					Code)			
Baltimore, permit. Pages 1 and Department of Healt Important: If Item 2 eny injury or other 2000.		20a. Method of Disposition  1  Burial 2  Cremation 3  F  1  Donation 5 Other (Specify)	C8	metery, cren	sition (Name of natory or other place S CEMETE)	RY FEB.	Date 3,2004		ation - City or To				
bermit. Departimonts Imports eny inji		21. Signature of Funeral Service Licens	Hellenken	1 FF	Name and Addrese LLOWS, HE	LFENBEIN ERTY ST.	CENTRE	VILLE	NERAL HO	OME, P.A. 1617			
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Non Small (III) long Cancer  Due to (or as a consequence of):											
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UNUSION OF VIKEL To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page.	tlon; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		R/Outpatien 28b. Time of Injury	28c. Injury Work	4 Nursing	ath (Check only or Home 5 Resid 28d. Describe h	ence 6 (	□Other (Specify	()			
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State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lester Howdvshell Eugene JANUARY 2004 10:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND MEMORIAL HOSPITAL ALLEGANY 5. Social Security Number If Under 1 Year | ff Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 15, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F Days 219-14-6354 79 Director Usual Residence of Decedent with the Maryland State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at ĂĨlegany Cumberland **Funeral Director** 1 XYes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 433 Williams Street 21502 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married be filed within 72 hours after ital Hygiene. 1 XYes 2 No If Yes, Give WWII Year or Dates: 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Railroad permit, Reges 1 and 2 should be filed w Department of Heelth and Mental Hygier important: if item 27 ie merked other th eny Injury or other traumatic event, III.a ODG. 17. Father's Name (First, Middle, Last)
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1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Hillcrest Memorial Park 1/31/2004 Cumberland MD \*4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Nam Scarbelli Fineral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 amus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a VENTRICULAR ARRHYTHMIA 30 MINUTES /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed for use as the burial-transit 4 YEARS AORTIC STENOSIS signed by the attending physicien and die detached for use as the buriet that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Wunknown peen HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed) certificate 1 Yes 2 ☑ No or Attending Physician; the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by after 4 | Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 28/4 D58853 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HABIB CHOTANI, M.D. P.O. BOX 265 GRANTSVILLE, MD 21536 31. Date filed (Month, Day, Year) JAN 2 9 32. Registrar's Signature State 9 2004 2000 Registrar outs

State of Maryland / Department of Health and Mental Hygiene 2004 05041 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:05P M January 30,2004 Jean Rennie Hanson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dorchester Chesapeake Woods Center Cambridge If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 4, 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funeral Days Hours 1 ☐ M 2 🛣 F Mary land Yrs 85 220-05-9199 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-f ehov the Medical Examiner must be notified at 1 Yes 2 No Cambridge Maryland Dorchester Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 21613 US 525 Glenburn Avenue or Iteme 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2XXXIVO If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes XXNo Specify: δ 3XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othe eny injury or other traumatic event, 9068. 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) James S. Rennie Eva Bragg 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 778 Cambridge, Maryland 21613 Daughter Terry H. Wright 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XX Cremation 3 Removal from State Salisbury Crematory 02/02/04 Salisbury, Maryland \*4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Thomas Funeral Home, P.A.
700 Locust Street Cambridge, Maryland 21613 21. Signature of Funeral Service Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATheroselesofic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physiclan/Medical Examiner physician and the burial-transit Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.0. be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 PNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Division or Attending 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 - Homicide filled in Hospital within 24 hours a 1 PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of pertific 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMBRIDGE MD-21617 300 AURORA ST. ARZA L MUHAMMAD 2004 32. Bigistrar's Signature **智B**Y 3 State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05042 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer **Physician** 30, JACOBS JAN. 2004 5:03 A LAUREN R. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☐ M 2 🕱 F APRIL 24,1946 Director 214-52-4414 WASHINGTON Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Director PRINCE GEORGES RIVERDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 61st AVE. 20737 U.S.A. 6327 Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FED. GOV'T. SECRETARIAL od 2 should be filed the and Mental Hygis 27 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be REBOL MILDRED ELMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 anu 2.
Department of Health and Importent: If Item 27 is any injury or other treat once. KENNETH N. JACOBS/HUSBAND 61st AVE., RIVERDALE, MD. 20737 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) CHAMBERS CREMATORY 1-31-2004 RIVERDALE, MD. 21. Signature of Funeral Service Lice see CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 TYes 2 🗆 No 3 🗌 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 2 12 No Division of Vital To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No Hospital: ↑ Impatient To 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Mainner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. Within 2 29c. License number 29b. Signature and title of/certif o completed cause of death (Item 23a) (Type, Print) 30. Name and ddress of person 32. Registrar's Signature 31. ate filed (Month State 2004 Registra

			1 - For Amend Item #5 Registrar		29 3/8/UA Ce	tas rtificate of	Death			004	
	Physici	an	1. Decedent's Name (First, Middle, Last) $01 iver$		Jeff	erson		2. Date of Dea Month Januar	Day	Yeer	3. Time of Death 11:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give: 6604 G Street	street and number)			or Location of Deat	h	4c. Cou	inty of Deeth	eorge's
	Funeral		Social Security Number     6. Sex		In yrs. last birthday,						place (State or Foreign
į.	Director		219-16-1928	<b>X</b> M 2□ F	78 Yrs.	Months Days	riours Mill.	8. Date of Birt (Month, Da) June22	,1925	Mar	yland
	/land		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or L	ocation				-	10d. Inside City Limits
	Ba-f et	Director	Maryland Calve	ert		Hunting	town				1 ☐ Yes 2 No
	with the a or 2		10e. Street and Number 1995 Emmanuel	Church R	oad	10f. Zip Code	639		10g. Citizen	of What Coul SA	ntry?
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23s or 28s-1 ehow uther than "natural", or Items 13s or 28s-1 ehow ent, the Medical Exacilizer must be rodified at	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H	dispanic Origin? (S	Specify Yes or No- to Rican, etc.)	- 14. F	Race - Americ	
30	s after	by Fu	1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ <b>X</b> es 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No				ocity: B1a	
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Mar	d 2 sho h and 7 is mu traumu		19a. Informant's Name/Relationship (Ty Ruth Curtis/nie			ing Address (Street  O Kavwo					MD 20721
ē,	f Health item 27 other tr		20a. Method of Disposition		20b. Place of Disp		7	Date		on - City or To	
saltimore,	Pages ment of ant: If it ury or o		1	iemoval from State	Plum Pt	. UMC C	em. 2/4				wn, MD
Ball	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke eny injury or other traumatic gnce.		21. Signature of Funeral Service Licens  Placky G.	evell	j² P	2. Name and Addre 451 Dare rince F	es Beac rederic	ewell F h Road k, MD 2	unera 0678	1 Hor	ne
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that ceused th ne cause on each line.	ne death. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
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8760	ate be executed obysician and the burial-transit	dical E		d							
9	certificate be executed nding physician and use as the burial-transit	/Med	IF FEMALE:	23c. If yes, outcome of	Bragnang/						
ROX	atter atter for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live birth 2   4 ☐ Pregnant at tin	Fetal death 3	☐Ectopic pregnanc	у			Date of delive Month	ery Day Year
<u>о</u>	at the de by the a	hys	9 Unknown	9□ Unknown							
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con	ntributing to death but	not resulting in the i	underlying cause giv	ven in Part I.		obacco use c ′es 2 □ No		he cause of death?
COL	w require been si should I	Completed						24a. Was		b. Were auto	ppsy findings available
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VIta	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:,		O#		ath (Check only o		7	Friend's
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Division of Vital Records,	i Si the	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.		reet, factory, office		28f. Location (S City or Tow		mber or Rura	al Route Number,
1	Hospital 4 hours Funeral ely filled	dical Ce	(Check only 2 Medical Exami	sician: To the best of iner: On the basis of ea	xamination and/or it	th occurred at the travestigation, in my o	me, date and place	e, and due to the curred at the time, o	cause(s) and date and plac	manner as s	tated. o the cause(s)
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	6+1		30. Name and address of person who co	ompleted cause of dea		nway Ct	. Dr.	Greenbe	1t, M	ID 207	770
	Sta		31. Date filed (Month, Day Year)	32 Registra	s Signature						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05044 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year JAN. 7:30 PM 28, 2004 ANN KUNEC MARY 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number, MONTGOMERY BETHESDA SUBURBAN HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 1 □ M **X**□ F Days Hours OCT. 18,1928 PÁ 164-22-3942 75 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 □ No MONTGOMERY ROCKVILLE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? STEPHALEE LA. 20852 U.S.A. 11209 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LAW FIRM 12 LEGAL SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SUSAN LUTCHKO ALBERT **GEMSKI** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHALEE LA., ROCKVILLE, MD. 20852 JOHN A. KUNEC/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ^ 4 □ Donation 5 □ Other (Specify) CHAMBERS CREMATORY 1-30-2004 RIVERDALE, MD. 21. Signature of Funeral Service Lightsee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) uremia Due to (or as a consequence of) Liabetic nubbro bat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o s a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No. 3 ☐ Probably 4 ※ Unknown vousculardisease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an wden autopsy performed? 1 Yes 2 No 1 Yes 2 No Objesite 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier KNOSdul 2300 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Betheoola 4915 Aubun NOSSULI 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Physician

/Medical

Examiner

**Funeral** 

Director

or items 23a or 28a-f show

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Hygiene.

and Mental Hygi

injury or other traumatic event.

bepartment of Health and Mental Limportent: If Item 27 is many supported.

Physician

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

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Examiner

Certification: To Be Completed by Physician/Medical

Medical

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To the Hospitel or Attending Physician:

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completely filled

FEB 0 2 2004

Charles

State of Maryland / Department of Health and Mental Hygiene 2001 05045 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:00 a M January 30, 2004 Philip Andrew Kozak /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring
Under 1 Year | If Under 24 Hrs. Holy Cross Hospital Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min 1 ☑ M 2 ☐ F Months Director 068-07-2291 89 May 4, 1914 New Jersey Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show The Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11730 Huggins Drive Funeral 20902 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 1 ☐ Yes 2X No Specify: White þ 3 X Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Printer/ Copy Editor Government Printing Office other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew P. Kozak <u>Elizabeth Ruyak</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 l Barbara Ann Kozak/ Daughter 11730 Huggins Drive, Wheaton, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 5 Pages injugyor 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 2004 4 Donation 5 Other (Specify) St. Mary's Cemetery Rockville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring.MD 20901 Marries & 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a Aspiration Pneumonia disease or condition resulting in death) 7 days /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Criscos or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran resulting in death) Last Due to (or as a consequence of). Box 68760. attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Atrial Fibrillation, Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 🗆 No 2X No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ⊠ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated one 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number Essen D D20400 January 30, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark S. Rosen M.D. 3941 Ferrara Drive, Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 02 oaks Ruda Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 05046 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** P M 2004 30. Joseph M. Kirshner January 2:51/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F Director 222-03-3330 84 August2,1919 New York Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 structured by giene.
Department of Health and Mental Hygiene.
Important: if Item 27 is marked other than "natural", or Items 23e or 28e-1 encount injury or other traumatic event, the Medical Examiner must be multiled at once. 1 Yes 2 No Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9234 E. Parkhill Dr. 20814 12. Was Decedent Ever in U.S.
Armed Forces?

1 MYes 2 □ No
If Yes, Give
Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physicist Harry Diamond Labs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham Kirshner Lena Blumenfeld 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Kirshner-Wife 9234 E. Parkhill Dr. Bethesda, MD 20814 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State \* 4 □ Donation 5 □ Other (Specify) King David Cemetery 2/2/2004 Falls Church, VA 22. Name and Address of Facility Hines-Rinaldi F.H. 21. Signature of Funeral Service Light 11800 New Hampshire Ave. Silver Spring, MD20904 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NON-HODGKINS Lymphoma Physician omo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Securations list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetat death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day 5 Other (specify) ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signi page 2 should be End Stabe renal disease 1 Tyes 2 🖫 \wp 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 2□ No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident investigation within 24 hours after death To the Funeral Diractor: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number means-muskwell ID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melissa Lynn Means-Markwell, M.D. 8901 Wisconsin Avenue; Bethesda, MD 20889 31. Date filed (Month, Day, Year) FEB 0 4 32. Registrar's Signature State oaks! Registrar

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	/Medic Examin		4a. Fecility Name (If not institution, give st Bedford Court Heal		er	4b. City, Town, or Loc Silver S			4c. County of Deat Montgome	
	Funeral Director		5. Social Security Number 6. Sex 577-44-2266	7. Age (In yrs. 92			Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Y Sept. 30	(ear) 9. Birti Co 1911 Vir	hplace (State or Foreign untry) ginia
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36	rs after death '', or Iteme 2	by Funeral	11. Marital Status 1  1 Never Married 2 Married 3 Never Married 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1	1	Was Decedent of Hispa f Yes, specify Cuban, N 1 ☐ Yes 2 1 No S	nic Origin? (Sp fexican, Puerto pecify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: 7	
00-6121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy orienter: If Item 27 is marked other than "natural", or Items of the notified at once.	Completed !	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired) listrative	ig most of work	ing	b. Kind of Business/	
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Division of Vital Records,	ding Physicien: The h. After this certificate ha funeral director, page	tlon: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	ot 3 DOA Other:		h (Check only one) ome 5 Resident 28d. Describe how	ce 6 Other (Specinjury occurred	oify)
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DHMH 17 Rev 1/2001

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Mar	and and is m		19a. Informant's Name/Relationship	p (Type, Print)	19b. Maili	ng Address (Street	and Number or Run	al Route Number, (	City or Town, State,	Zip Code)
e S	and ealth m 27		Mary A. Deoudes	/ Daughter	3915	Baltimo	re Street	, Kensin	ton, MD	20895
pairimore	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition 1   Substituting Substitution 3  Substituting Substitut	☐Removal from State	20b. Place of Disponentery, cres	osition (Name of matory or other place .e1's Cemet		uary 9	oc. Location · City o	,
Dall	permit. Departn Imports sny inju		21. Signature of Funeral Service Li	Censee Colo	F	2. Name and Addres	ss of Facility Collins	Funeral 1	Home Inc	
Н			23a. Part1. Enter the disease, or co shock, or heart failure. List or	on plications that caused	the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arres	lver Spri	ng, MD 20901
	Physician		Immediate Cause (Final	V .					,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		emorrhagic	Cerebrov	ascular A	ccident		Week
	Examiner			500 to (01 as a	consequence on.					
	*	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequence of):					
	icate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events							
ĵ	an ar	Ex	resulting in death) Last	Due to (or as a	consequence of):					
00,	ysicia ysicia ne bu	edicat		d						
0	ntifica ng ph as th	Med	15.551.41.5							
Š	death certifica attending ph for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		Ectopic pregnancy			23d. Date of de	elivery
	e dea he at ied fo	sici	in the past 12 months?  1 Yes 2 No	4□Pregnant at t 9□ Unknown		Other (specify)			Month	Day Year
	at the	Phy	9 Unknown							
ñ	uires that the de	by	Part II. Other significant conditions	s contributing to death but	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
5	w require	ted						1 🗆 Yes	2 🖾 No 3 🗆 P	robably 4 Unknown
נ	elawr has be je 2 sh	Completed						24a. Was an	24b. Were a	utopsy findings available
	The ate h page	Jour L						autopsy performed 1 ☐ Yes 2 X	<pre>d? death?</pre>	completion of cause of
2	ysician: The is certificate his director, page	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Chark ask asa)		
-	Physic this co	ို	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatien	t 3 DOA Othe	er: 4 Nursing Hor	HOSp1t Te 5☐ Residenc	als Ira	nsitional <sup>city)</sup> Care Center
) =	ding Ph h. After th funeral	 	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Yeer) 28b. Time of Injury	28c. Injury Work	at :	28d. Describe how	injury occurred	- " Care Center
2	eath. or: A	cati	2 Accident investigat				res 2 □ No			
	or Att	Certification:	3 Suicide 6 Could not determine		ry - At home, farm, stre (Specify)	eet, factory, office	1	28f. Location (Stree City or Town, S	t and Number or R	ural Route Number,
ב	urs al urs al ural D		<u> </u>	1					,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 ☆ Certifying (Check only one)	Physician: To the best of aminer: On the basis of e and manner state	examination and/or inv	occurred at the tim restigation, in my op	e, date and place, a pinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	To t Com	Σ	29b. Signature and little of certifier			29c. License	number	29d.	Date signed (Mont	h, Dey, Year)
	10		A	Nawas		D5(	188	- <	2-5-	04:
			30. Name and address of person wh	o completed cause of de	ath (Item 23a) (Type,	Print)	0 1			000
			AHMED NAW	AZ 10 BO.	x 83810	7 Cla	ilhersb	nig 1	mo 20	- 580 -
	Stat Registra	_	31. Date filed (MOER Bay, Year)	2004 32. Registrar	ath (Item 23a) (Type, X 838 (C	Som Ke	· ·	0		

			1 - For State Registrer	State of	Marylar	nd / Depa <i>Cei</i>	artmer <i>rtifica</i> i	nt of Ho te of E	ealth ar Death	nd Me	ntal Hyg	iene 2	004	05050
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Kathryn Louise								. Date of Dea Month anuary	Davi	004 <sup>Year</sup>	3. Time of Death 11:32 PM
	Examin		4a. Facility Name (If not institution, give Anne Arundel Medi				Anr	apol:					unty of Death ne Arui	nde1
	Funeral Director		213 10 0101	M 201	7. Age (In yrs. 63	last birthday) Yrs.	If Unde Months	Days	If Under 24 Hours	Hrs. 8 Min. M	Date of Birth (Month, Day arch I	4 <sup>Year)</sup> 19	9. Birthp Cour 40 Wasi	lace (State or Foreign http: nington, D. C
	hours after death with the Maryland tural', or items 23e or 28e-f show al Examinational be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arus	ndel		ty, Town or Lo	er			-				0d. Inside City Limits 1 Tyes 2 No
	sath with It s 23s or 2 cust be m	eral Dire	3459 S. River Ter	race	tent Ever in I	10 12 1		2100		2 (Speci	ly Yes or No-		of What Cour USA Race - Americ	
036	ours after de rai', or item Examinar	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Ford  1 Tes 2  If Yes, Give  Year or Da	c <b>es?</b> 2 [_ANo <del>9</del>		f Yes, spe	cify Cubar	Specify:	Puerto Ri	can, etc.)		Black, White, ecify: USA	etc.
9500-6121	be filed within 72 hours after death with the Marylan Ital Hyglene. Id other than "natural", or liems 23a or 28a-f show event, the Medical Exumitive must be multified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-	4or 5+)	1	dent's Usu kind of wi DO NOT u nemak	ork done d use retired)	tion uring most o	f working			of Business/Ind	dustry
Maryland 2		To Be Co	17. Father's Name (First, Middle, Last) Paul Edward Habe:	r, Sr.							First, Middle, Charlo		mame) obinsor	1
	od 2 s	6 8	19a Informant's Name/Relationship (7) Ronald E. Kraft/	pe, Print) Husband		3459	S. R	liver	Terra		dgewat	er,Ma	own, State, Zip	21037
Baltimore,	permit. Pages 1 as Department of Hea Important: if item any injury or other once.		20a. Method of Disposition  1 ⊕ Burial 2 □ Cremation 3 □ F  1 □ Donation 5 □ Other (Specify)  21. Signal / 6   Funeral Service Livens		tate La	Place of Dispo cemetery, crer kemont	Mem'	1.Gai	rdens	1-31	-04	David		Le,Md.21035
g	permi Depa Impo any ii	9 3	23a. Part1. Enter the disease, or compl		used the dea	29	973 S	olomo	ons Is	1and	Rd.,E	dgewat	Funera ter, Mo	1 Home 1. 21037 Approximate
	Priysician /Medical Examiner		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on ea	ch line.	rebra								Interval Between Onset and Death 2 4
8/60,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated se vents resulting in death) Last	Due to (c	or as a consec									
O. Box 6	The law requires that the death certificate has been signed by the attending tagge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 □ Feta ant at time of c	aldeath 3□	∃Ectopic p ∃Oth <i>e</i> r (s	pregnancy				<b>2</b> 3d.	Date of delive	ory Day Year
ı	quires that n signed by uld be deta	b	Part II. Dther significent conditions co	ntributing to de	ath but not re	sulting in the u	nderlying	cause give	n in Part I.		23e. Did to			ne cause of death? ably 4 \( \subseteq \text{Unknown} \)
Division of Vital Records,	aician: The law requir s certificate has been si lirector, page 2 should	Completed									24a. Was a autops perform	SV	prior to cor death?	psy findings available mpletion of cause of
Z =	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	lospital:				Othe	MP*		Check only or			
on of	ting Phy n. After this funeral d	tlon; To	1 Tyes 2 No '  27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date o		28b. Time o Injury		28c. Injury Work	4 🗆 Nursi	28	5 □ Reside		Other (Specify courred	r)
Divisi	P S S S	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place buildin	of Injury - At h g, etc. (Speci	nom <i>e</i> , farm, str	eet, facto	ry, office		28	I. Location (Si City or Town		umber or Rura	l Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier Check only one) Certifying Phy 2 Medicel Exami	sician: To the ner: On the ba and mann	best of my kn sis of examin er stated.	owledge, deatl ation and/or in	n occurre vestigatio	at the lim n, in my op	e, date and pinion, death	place, an occurred	d due to the c at the time, d	ate and pla	ce, and due to	the cause(s)
•	To the within 2 To the complet	Σ	29b. Signature and title of certifier	no		m 23a) (Type, Lical Pla ature	29	D3/	997	2	2	9d. Date si	gned (Month,	Day, Year)
			30. Name and address of person who co	mpleted cause	of death (Ite	m 23a) (Турө, Цсг Ри	Print)	ste ra	Ann	HADL	15, 1	O 2	21401	
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 2 2	32. R	gistrar's Sign	ature	loans	t a						

DHMH 17 Rev 1/2001

7		1 - For State Registrar Amend Item#5pe: 1. Decedent's Name (First, Middle, Last)	State of Ma rFHG8282/25	aryland / Depa 6/04 EW Cer	artment of H tificate of I	lealth ar Death		Reg. No.	04 Year	0.5 (	Death
Physic /Medi Exami	cal	MARY R. KLEPPER  4a. Facility Name (If not institution, give s	treet and number)	5	4b. City, Town, or	r Location of (	FEBRUAL	4c. County	04	8:30	<b>A</b> <sup>M</sup>
Cxamii	ilei	324 WICOMICO ROAD			STEVENS		He La Division		ANNE		-
Funeral Director		5. Social Security Number 6. Sex 1 C	7. Ag	e (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	Hours	Min. 8. Date of Birt (Month, De) Oct 5 19	y, Year)		ice (State or y) TAND	r Foreign
<u> </u>		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10	d. Inside Cit	v Limits
Maryla f shov	tor	MD QUEEN AN	INE 'S	STEVENSVI						1 🗆 Yes	
ith the or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Count	ry?	
sath w		324 WICOMICO ROAD	12. Was Decedent	Ever in U.S. 13. \	21666 Was Decedent of H	ispanic Origin	n? (Specify Yes or No	USA 14. Race	e - America	n Indian,	
72 hours after death with the Maryland natural; or Items 23a or 28a-f show dical Examiner must be notified at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 1  If Yes, Give Year or Dates:	No	f Yes, specify Cuba	in, Mexican, F Specify:	Puèrto Rican, etc.)	Specify	k, White, e		
within 72 hours after death with the Marylan liene. Than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	(Give life. L	dent's Usual Occup kind of work done o DO NOT use retired	during most o	f working	16b. Kind of Bu		ıstry	
it is by the		12 17. Father's Name (First, Middle, Last)	2	TEAC	HER	18. Mother's	Name (First, Middle,	EDUCAT Maiden Surnam			
S a b s	o Be	PAUL T. ROSSBACH,	SR.			CATHE	RINE FLARE	RTY			
2 2 8 8		19a. Informant's Name/Relationship (Ty					or Rural Route Numbe				
1 and 1 Health Health tem 27 other tr	1 3	VIRGIL KLEPPER/HUS  20a. Method of Disposition	BAND	20b. Place of Dispo	sition (Name of	1	STEVENSVIL.  Date	LE, MD 20c. Location -	21666 City or Tow		
		1 YBurial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other place		2/07/2004	OUEENST	OWN.	MD	
permit. Page Department of Important: If any injury or		21. Sign to e of uperal Service License	Leg,	7/ 22 FF	Name and Addre	ss of Facility ELFENB	EIN & NEWN, CHESTER,	AM FUNER	RAL EC		.A.
cate be executed  Cate be exec	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.		Due to (or as	<i></i>	ny se ma					Onset and D	leath
death certifi e attending I d for use as	Physician/Me		3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	′		23d. Dat Mor	e of deliver		'ear
<u> </u>	þ	Part II. Other significant conditions cor	ntributing to death b	out not resulting in the u	nderlying cause giv	en in Part I.		obacco use contr es 2 No			
- CO L.L.	Completed						24a. Was autop perfo 1 🗌 Yes	rmed?	Vere autoportion to combleath?	sy findings a pletion of ca	ivailable iuse of
sician certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗷 No	lospital: 1 ☐ Inpatie	ent 2 ER/Outpatien	oth Oth	er	Death (Check only only only only only only only only		(C		
ng Pl		27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Inju (Month, Da	ury 28b. Time of	28c. Injun Wor		28d. Describe h	now injury occurr			
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (S City or Tox	Street end Numbern, State)	er or Rural	Route Numb	⊃0 <i>r</i> ,
Hospi 24 hour Funerately fills	Medical (			of my knowledge, death of examination and/or in- ated.							
To the Youthin To the comple	Mec	29b. Signature and title of certifier	albech, H		29c. Licens	e number		29d. Date signed	2004	ey, Year)	
		30. Name and address of person who co	empleted cause of c	death (Item 23a) (Type, idgely Avenu	Print) # 121	Annal	nolis, MD				
Si Regis	tate trar	31. Date filed (Month, Day, Year) FEB 0 5	32. Registr	rar's Signature	Coule						

State of Maryland / Department of Health and Mental Hygiene, 05052 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Creasy ewellen 10:27 PM 2 CO4 03 -than Inomas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner University of Maryland Medical Center 5. Social Security Number 6. Sex 7. Age ( Baltimore Baltimore City ff Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F N/A 01/24/2004 Director Maryland Usual Residence of Decedent 10d. Inside City Limits deeth with the Maryland 10c. City, Town or Location 10a. State 10b. County or Items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 308 Waterton's Way 21085 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Item any injury or other traumatic event, the Mudicul Experiment 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Michael J. Lewellen Dana C. Creasy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Waterton's Way - Joppa, MD Michael J. Lewellen (father) 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gardens 02/14/2004 Fallston, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, MD 21087 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Deosis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed the burial-transit terluce a attending physicien and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) P. 0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy performed' 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 2 ER/Outpatient 1 Inpatient 3 DOA Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injun ours after death. nerel Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funerel Medical tractifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Univer Maryland Medical Center 22 S Greene St. Batto, MI) transcene 32. Registrir's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05053 State
RegistrarAMEND ITEM #10e&22 PER FH G828 2/18 COArtificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Vaar Carl W. Leasure 2004 FEBRUARY 11, 16:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth 9. March 10,1932 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 PA **Funeral** Hours 1 GM 2□ F Director 213-24-6556 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. toside City Limits or 28e-f show Examiner must be notified at Completed by Funeral Director 1 ☐ Yes 2 ☐ No MD Allegany LaVale, \* 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Campground Road 21502 or Items 23a USA Pages 1 and 2 should be filed within 72 hours after death in nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "naturat", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1√2 Yes 2 No 1952 trYes, Give Year or Dates: 1954 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩idowed 4 Divorced other treumatic avant, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ~ Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oscar Leasure Ida (Blubaugh) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt 1, Box 477, Ridgeley, WV 26753 - Son Mike Leasure 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. Burial 2 ☐ Cremation 3 ☐ Removal from State SS Peter & Paul 2/14/04 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 2 Conature of Funeral Pervice 22. Name and Address of Facility Hafer Funeral Service PA LA 1302 E National Hwy, LaVale, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause onleach line. Approximate Interval Between Onset and Death Immediate Cause (Finat **Physician** ITTHOSIS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-1 Due to (or as a consequence of): ohysician Physiclan/Medical the as attending <sub>I</sub> tF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Į, Dav 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f ☐Yes 2☐No 9 Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown strointestinal Bleed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 Yes 2 X No 1 Yes 2 No ector. 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (\*\*peq·fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitet 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Te brown D36766

State Registrar

DHMH 17 Rev 1/2001

Box 68760

P.O. I

Division of Vital Records.

**ORIGINAL** 

CUMBERLAND, MD 21502

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

8 2004 >

POONAI, VIK, M.D.,

FEB

31. Date filed (Month, Day, Year)

924 SETON DRIVE,

32. Registraris Signature

			State of Sta	f Maryland / Dei LG8282/25/04 🕏	oartment of Health and prtificate of Death	Mental Hygiene 20 (	04 05054
F	Physici	an	1. Decedent's Name (First, Middle, Last)	A		Date of Death     Month Day Y	3. Time of Death
	/Media	al	4a. Facility Name (If not institution, give street and nun	nber)	4b. City, Town, or Location of Dea	th 4c. County of	Dogth
	Examir	ier	Holx Cross A	TOSP	5/1/00 9	$\sim$	Doner
100	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hr Months Days Hours Wir		Birthplace (State or Foreign
\$	Director		568-30-9113 Usual Residence of Decedent	86 Yrs.			ietnam /
	/land		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Many Many	ctor	Maryland Montgomery	Si	lver Spring		1 □Yes 2 図 No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g. Citizen of Wha	at Country?
	death with the Maryland ms 23a or 28e-f ehow Frosst be notified at	rai	11122 Easecrest Drive		20902	USA	
10	fter de r item inerr	Funeral	11. Marital Status 12. Was Dece Armed For 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes	dent Ever in U.S. 13 ces? 2 5tNo	Was Decedent of Hispanic Origin? (     If Yes, specify Cuban, Mexican, Pue	no Rican, etc.)	American Indian, White, etc.
93	72 hours after naturel', or ite ilical Examine	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Giv Year or Da	e ites:	1 ☐ Yes 2 🙀 No Specify:	Specify:	Asian
21215-0036	n 72 hours after death with the Marylan "neturel", or items 23a or 28e-f ehow edical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupation ve kind of work done during most of we	orking 16b. Kind of Busin	ness/Industry
12	d within giene. ir than "	duc	Elementary/Secondary (0-12) College (1	-4or 5+)	. DO NOT use retired)		
	be filed ita! Hyg id other event,	Be C	17. Father's Name (First, Middle, Last)	JBOJE	lcaster/Translator	Woice of time (First, Middle, Maiden Sumame)	America
/lar	should by nd Menta marked matic ev	ToE	Ly Duc Hai		Nguyer	Thi Huven	
Maryland	2 should have and have lama		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street and Number or F	lural Route Number, City or Town, Sta	ate, Zip Code)
	s 1 and 2 should if Health and Men if Health and Men item 27 is marke other traumatic	2	Loan Thi Nguyen Ly  20a. Method of Disposition	20b. Place of Dist	position (Name of	Silver Spring, N Date 20c. Location - Cit	laryland 20902
JOL.			1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S 14 ☐ Donation 5 ☐ Other (Specify)	comotoni ci	Heaven		
Baltimore,	permit. Page Department of mportant: If iny injury or ince.		21. Signature of Funeral Service Licensee		22 Name and Address of Facility	.4,2004 Silver S;	
ä	Depa Impo any ii	1, 1/2	). Ken Skila		rancis J. Collins 00 University Bly	Funeral Home, Ind., W., Silver Spri	nc.
ų.			23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	aused the death. Do not e	nter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Vozania	: shock		Onset and Death
	Examiner		Due to (c	or as a consequence of):	C./		10
		Jer	Sequentially list conditions, I any leading to in mediate cause. Enter Underlying Cause (Disease or injury	or as a consequence on:	an toll		
	executed in and ial-transi	Examiner	that initiated events C.	hrom bo	corpopenia	- 1 - nw	t 3 d
8760,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (	or as a consequence of):	2	La Fal wo	10
687	ficate be physicial s the buri	edicai	dP	7 51 11	conjar throp	43/2	7 0
Box (	death certifica e attending ph id for use as th	Physician/Med		come of pregnancy	W W	23d. Date o	f delivery
œ.	0 0 0	sicia	in the past 12 months?  1 Yes 2 No 4 Pregna	ant at time of death 5	□ Echapic gregnancy □ Other (specify)	Month	-
P.O.	that the death led by the atter detached for i	Phy	a □ oukuowu			37	
	56 76 90	d by	Part II. Other significant conditions contributing to de	1 CC	underlying cause given in Part I.	23e. Did tobacco use contribu	Te to the cause of death?  ☐ Probably 4 ☐Unknown
Division of Vital Records,	w require been sign	Completed	atrial Can	1. 6			re autopsy findings available
Re	The law cate has page 2	omp	A TITLE TO THE TENTE	7.0//05		autopsy prior deat	r to completion of cause of th?
ital	certificate rector, pag	Be C	25. Was case referred to medical		26. Place of De	1 ☐ Yes 2 X No 1 ☐ ath Check only one)	Yes 2 No
of V	Attending Physicien: The rideath. cleath. ector: After this certificate hoy the funeral director, page	ToE		patient 2 ER/Outpation	ent 3 DOA Other: 4 Nursing I	Home 5 Residence 6 □Other (	Specify)
N C	ling P. After t 'unera	ion:	T I I I I I I I I I I I I I I I I I I I	n, Day Year) Injury	of 28c. Injury at	28d. Describe how injury occurred	
isic	Attend death ctor: y the	ficat	Accident investigation 3 Suicide 6 Could not be determined 28e. Place	of Injury - At home, farm, s		28f. Location (Street and Number of	or Bural Boute Number
<u>S</u>	ai or / s after if Dire	Certification:	4 Homicide determined buildin	g, etc. (Specify)		28f. Location (Street and Number of City or Town, State) / // 22 Silve: Spr/22 hv	Euse (Tes) Dr
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier (Check only 2 Medical Examiner: On the ba	best of my knowledge, dea	ath occurred at the time, date and place	e, and due to the cause(s) and manne urred at the time, date and place, and	or as stated
	the hin 24 the F nplete	Medical	and mann	er stated.			
	To voi		29b. Signature and title of certifier	- no	29c. License number	29d. Date signed (M	
	10		30. Name and address of person who completed cause	of death (Item 23a) (Type	p. Print)	JAN 30	2007
_			BRIAN Shew MU 13	00 Firest G	len Rd Silver SFA	ing MO 20910	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Re FEB 0 4 2004	gistrar's Signature	Locals Solver Spa		

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registra 05055 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Sui Tai Loi 1-29-04 3:05 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Mariner Health Care Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Director 579-62-4538 91 4-18-1912 <u>China</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or Items 23e or 28e-f ehow ury or other treumatic event, the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Md Montgomery Wheaton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2203 Reedie Dr. 20902 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 A No Specify: Completed by Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: Asian 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sous chef Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ka Sun Loi Lin Ho Lim 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chuck K. Yuen - Son 2203 Reedie Dr. Wheaton, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Loudon Park Crematory 2-7-2004 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Paneral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home DCG 11800 New Hampshire Ave., Silver Spring, Md 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 3 days Pneumonia /Medical Due to (or as a consequence of): **Examiner** Chronic Renal failure years Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit Hypertension years and Due to (or as a consequence of): P.O. Box 68760, physicien for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Day Year 4 Pregnant at time of death 5 Other (specify) detached ģ page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia of chronic diseases Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Senile cadrexia 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 🔽 No funeral director. 25. Was case referred to medical 26. Place of Death Check on one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 📆 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A 2 Accident the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Sign were and title of cer 29c. License number 29d. Date signed (Month, Day, Year) upus. D0013550 1-30-2004 30. Name and address of person who completed causy of death (Item 23a) (Type, Print) 8630 Fenton St. Suite 906 Silver Spring, MD 20910 Bernadette Soong M.D. 31. Date filed (Month, Day, Year) FEB 0 4 32. Registrar's Signature State oaks Registrar

Baltimore. Maryland 21215-0036

Division of Vital Records,

			1 - For State Registrar	State of Marylar	•	artment of H			ene 2004	05056
Nr.	Physici /Medic		Decedent's Name (First, Middle, Last)     RUTH		LOWE	NSTEIN		2. Date of Death Month FEBRUARY	Day 2004	3. Time of Death 1:20P. M
	Examir		4a. Fecility Name (If not institution, give Hebrew Home of Gre	ater Washingt		Rockvi			4c. County of Death Montgome	
R	Funeral Director		Usual Residence of Decedent	]M 2∏F	86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Sept. 15	,1917 New	olece (Stete or Foreign ntry) York
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural" or Itama 23a or 28a-f ahow event, the Medical Exert ner must be routiled at	I Director	Maryland Montgome:  109, Street and Number 6121 Montrose Road	ry R	ty, Town or Lo			10g	o. Citizen of What Cour United St	10d. Inside City Limits 17 Yes 2 □ No  ntry? tates
JU36	ours after death iral', or Itama 2:	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2☐ No If Yes, GiveX Year or Dates:	l I	Vas Decedent of H i Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rece - Americ Black, White, Specify: Whit	etc.
21212-0030	be filed within 72 h tal Hygiene. d other than "natu event, I.a Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life. L Secre		during most of work ()	ing	private	dustry
/land	should be fit nd Mental H marked oth matic even	ø	17. Father's Name (First, Middle, Last)  Martin	La	nge		Matilda	e (First, Middle, Ma		ınk)
, mar	permit. Pages 1 and 2 should by Oppartment of Health and Menta Important: If item 27 is marked any injury or other traumatic es ance.		19a. Informant's Name/Relationship (Ty Marilyn Kessler -	Daughter	7611	Whittier	Blvd. Be	ethesda, N	City or Town, State, Zip	0817
saitimore,	Pages 1 ment of H ant: If ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ P  4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery, cren	sition (Name of natory or other place)  Im Mem. G	e)		c.Location-City or To est Palm Be	
Pail	permit. Depart Import any inj		21. Signature of Funeral Service Licens.  Donald US	ngward	Dc 44	Name and Address nald V. 100 Powde	Borgwardt r Mill Ro	Funeral 1. Beltsvi	Home, P.A. lle, Maryl	and 20705
	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the deat ne cause on each line.  At here solver.  Due to (or as a consequence)	etic	<b>\</b> \ \	g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
g/on,	certificate be executed and nding physician and seas the burial-transit	ai Examlner	Sequentially list conditions, if any, leading to inthe ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						
O. Box 68/	death e atter	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1  Yes 2  No 9  Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıl death 3□	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
ras, r.	requires that the reen signed by th hould be detache		Part II. Other significant conditions cor		culting in the un	derlying cause give	en in Part I.		cco use contribute to the	
II Records	The la ate has page 2	Completed by						24a. Was an autopsy performed	d? prior to cor	psy findings available impletion of cause of
n or vital	ng Physician: The ter this certificate hanneral director, page	on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No  27. Manual of Death 1 Natural 5 Pending	lospital: 1  Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Othe	4 Nursing Ho	th (Check only one) me 5 ☐ Residence 28d. Describe how	e 6 □Other (Specify	0
DIVISION	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif		1775	Yes 2 □ No	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	hospita 24 hours Funeral etely fillec	edical C	29a. Certifier 1 Certifying Physical Check only one)	sicien: To the best of my knoner: On the basis of examina and manner stated.	owiedge, death	occurred at the timestigation, in my op	e, date and place, pinion, death occurr	and due to the caus red at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
		Me	29b. Signature and title of certifier	100		29c. License			Date signed (Month, I	
	4		30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type, F	Print)	nckvilla.	Mari	1 2005	2005
- T	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 5 200	32. Registrar's Signa	ature &	Sparks	/	Ilan	c1 C00-	

			1 - For State Registrar	State of N	/laryland		artmen rtificate						e 2004	050	)57
g	Physici	an	Decedent's Name (First, Middle, La								2. Date of De Month		ay Year	3. Time o	f Death
	/Medic	cal	CHARLOTTE N. LEW  4a. Facility Name (If not institution, gi		(r)		4h City	Tour or	Location		JANUARY		. 2.004 c. County of Dea	8:00	P M
	Examir	ier	MANOR CARE POTOM		''/		POTO		Location	or Death			ONTGOMER		
Т	Funeral		5. Social Security Number 6.	Sex 7. A	Age (In yrs. last	birthday)	If Under Months	1 Year	If Under		8. Date of Bir (Month, Da			rthplace (State	or Foreign
	Director		185-05-09/6	1□ M 2\\\ F	86	Yrs.	Months	Days	Hours	Min.	04/21/1	917	PEN	NSYLVAN	IA
	and wo		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside C	City Limits
	Mary F sh	tor	VIRGINIA FAIRFAX		BURKE										2 <b>∑</b> No
	th the	Director	10e. Street and Number		DOIGE		10f. Zip	Code				10g. C	itizen of What C	Country?	
	23a c		9008 HOME GUARD	DRIVE			2201	15				U.S	.A.		
	er des items	Funerai	11. Marital Status	12. Was Deceder Armed Forces	5?	13.	Was Deced f Yes, spec	lent of Hi offy Cuba	spanic Ori n, Mexicar	gin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh		
920	urs aff	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 [ If Yes, Give Year or Dates	: WWII		1 ☐ Yes 2	2 <b>X</b> No	Specify:				Specify:	WHITE	
21215-0036	be filed within 72 hours after death with the Maryland that hygiene.  do other than "nature!, or liems 23a or 28e-f show so other than "nature!, or liems 23a or 28e-f show swent, the Modical Exerting trust by notified at	Completed	15. Decedent's 8 (Specify only highest gi	ducation		6a. Deced	dent's Usua	I Occupa	ition	t of workin	10	16b.	Kind of Business	s/Industry	
21	within ene. than "	mpie	Elementary/Secondary (0-12)	College (1-4o			kind of wor DO NOT us					O.M.C	OU MADI	· Da	
	filled v Hygie ther t		17. Father's Name (First, Middle, Las	<u>4</u>	A	DMIN.	ISTRA	TIVE			T (First, Middle,		OCK MARK	ET	
Maryland	id be lentai ked c	To Be	PHILIP	NEW	MAN			1	LENA		(, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		FRIEDMA	N	
ary	2 shou and N is mar	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address			er or Rura	Route Number		or Town, State,		
	2 # Z		LINDA E. LEWIS/DA	AUGHTER							RKE, VA	22	.015		
ore	0 = 0		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 [	☐Removal from Stat	e 20b. Place ceme	of Dispo etery, cren	sition (Nam natory or ot	ne of ther place	e)	D	ate	20c. l	Location - City o	r Town, State	
Baltimore,	permit. Pages Department of importent: if i any injury or once.		* 4 □Donation 5 □Other (Special Signature of Funeral Service Lice		NATI		CREMA				/2004	FAL	LS CHUR	CH, VIR	GINIA
Ba	permit. Departri Importe any inju		→ amanda >	Sudewed		DA 1.1	170 RC	SKY-0 OCKV	$rac{ ext{GOLDB}}{ ext{ILLE}}$	ERG I	. ROCKV	ILL	HAPELS, E, MD 2	INC. 0852	
ı			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caus one cause on each	ed the death. Dine.	o not ent	er the mode	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approxima Interval Be Onset and	tween
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ d	OVASCUL		CCIDE	NT						WEEK	
	Examiner		- (		s a consequen	,								YEARS	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. SEIZUR	s a consequent				·					LEANS	
	ocuted nd transit	Examin	that initiated events	c. CORONAL			ESEASI	Ε						YEARS	
,09	ie be executed ysician and e burial-transit	ai Ex	resulting in death) Last	Due to (or a	s a consequen	ce of):									
687	physics the b			d											
.O. Box	w requires that the death certificate been signed by the attending phys should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☒ No 9 □ Unknown		2 ☐ Fetal dea at time of death	ath 3 □	Ectopic pre Other (spe						23d. Date of de Month	-	Year
Δ.	requires that the teen signed by th hould be detache	y P	Part II. Other significant conditions	contributing to death	but not resultin	g in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	obacco	use contribute	to the cause of	death?
ğ	equire en sig ould b	ted t									10	Yes 2	2 □ No 3 □ P	robably 4 🛚	Unknown
ecc	2 2 2	Completed							····		24a. Was	sy	prior to	utopsy findings completion of	available ause of
E E	cate h	Con									perfo	rmed? 2 N	death? o 1 ☐ Ye	s 2 No	
Vita	ding Physicien: The In. After this certificate ha	Be	25. Was case referred to medical examiner?	Hospital:				A Othe			(Check only o				
ō	Phys	٦.	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of In	tient 2□ER/ jury 28t	Outpatien b. Time of		Bc. Injury Work	4771140		ne 5∐Resid 8d. Describe f		6 ☐Other (Speury occurred	ecify)	
ion	nding ath. r: Afte e fune	atior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		ay Year)	Injury	м		? ′es 2 🔲	No					
Division of Vital Records,	or Attsnatter deat Director: in by the	Certification:	3 Suicide 6 Could not be determined	289. Place of I	njury - At home, etc. (Specify)	, farm, str	eet, factory,	, office		2	8f. Location (S City or Tov		und Number or F	Rural Route Nun	nber,
	Hospitel or Attanding 24 hours after death. Funerel Director: After tely filled in by the fune														
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medicai		hysician: To the bes miner: On the basis and manners	of examination										s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	2			290.	. License	number	~ ^		29d. Da	ate signed (Mon	th, Dey, Year)	
•	5		70	Ray	)		ر	1)3	> /	72		JANU	JARY 29,	2004	
	and the state of t		30. Name and address of person who SWAROOP G. RAO,				,	#50	4. RC	OCKVI	I.I.F. M	4 RYT	LAND 208	352	
33	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature					, OLC V.L					
<b>\$</b>	Registr	ar	FEB 02 2	.004	never	ful	MO	all.							

State of Maryland / Department of Health and Mental Hygiene 2004 05058 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Vear **Physician** 09:50 A<sup>M</sup> 29, Myrtle Leidman January 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring
H Under 1 Year | H Under 24 Hrs. Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Hours Min. 1 M 20 F Director 125-05-2232 87 23, 1916 Nov. Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28e-f show Examiner must be notitled at Director 1 X Yes 2 □ No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code With Items 23a Funerai 1704 Tilton Dr. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 14. Race - American Indian. Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 💆 No þ Specify: 3 Widowed 4 □ Divorced ear or Dates "natural", White Completed 15, Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental f Health and Menta 2 Julian Shapo Mary Casper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) injury ar-other t Julian Leidman-Son 940 Wayne Ave. Silver Spring. MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If the
eny injury gr.ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 1/30/2004 King David Cemetery Falls Church, VA 22. Name and Address of Facility Hines-Rinaldi F.H. 21. Signature o Funeral Service Lyensee lant. 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part . Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician a Acute Exacerbation Chronic Bronchitis resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Cluses or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown څ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 XNo 3 ☐ Probably 4 ☐ Unknown Lymphoma Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2**X** No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpalient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Alter 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours aft Funeral Di letely filled in 29a. Certifier 🛣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D12121 January 29, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Sengstack MD 3929 Ferrara Dr. Silver Spring, MD 20906 31. Date filed (Month, Day, Year, 32. Registrar's Signature State FEB 04 souks

Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 27 200 LAZEROW /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner WASHINGTON HAGERSTOWN WASHINGTON COUNTY HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yee) 05/23/1906 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months MARY LAND 1 M 2 □ F 97 Director 217-32-1582 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County or 28e-f ahow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director WV MORGAN BERKELEY SPRINGS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Items 23a 1331 MOUNTAIN RUN ROAD 25411 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 ō 1 ☐ Yes 2 No Specify Specify: WHITE 3 Nidowed 4 Divorced 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) JEWELRY JEWELER 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt. Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other traumatic event Be LAZEROW ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 331 MOUNTAIN RUN RD., BERKELEY SPRINGS, WV 25411 FRANCES LAZEROW/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition injury or 2 □ Cremation 3 □ Removal from State UNITED HEBREW CEMETERY 01/30/2004 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun , al Service Licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

COUNTY APPERT DISEASE 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No PNEUMON iA 24a. Was an director, page 2 autopsy performe CHOVE LITHIAS! 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No atient 2 ER/Outpatient 3 DOA Certification: To funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Contifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the date of the cause of the 29a. Certifier Medical (Check only one) and manner stated. To the ! 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Lamoure D60764 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HILL AVE, HAGERSTOWN, MD21742 12931 SPANISLAV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 04 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar 05060 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:55 am 2, 2004 February Broudise Ruth Lard /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Manor Care- Wheaton 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F 251-07-6921 85 1918 South Carolina Director Nov. 18. Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County in than "neturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 TYPS 2 NO Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 13327 Foxhall Drive USA Funeral 12. Was Decadent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "neturel", or Ite 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☒ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own 12 Homemaker Home injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Smith Sally V. Ickner ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford Lard/ Husband 13327 Foxhall Drive, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition February 1 Burial 2 □ Cremation 3 □ Removal from State 2004 Silver Spring, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. Š Jme 500 University Blvd. W., Silver Spring, MD 20901 23a. Pent 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. Zist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Months Malnutrition /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) the attending physician Physician/Medical as the IF FEMALE 950 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Year for Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Hinknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 3 ☐ Probably 4 ☑Unknown 1□Yes 2□No Gastroenteritis Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Dementia autopsy performed? 1 ☐ Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 1 ☐ Yes 2 XNo 2 ☐ ER/Outpatient 3 DOA Sign filled in by the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical pletely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D32332 February 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh K. Gupta M.D. 9801 Georgia Avenue, Suite 220, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) FEB 0 4 2004 32. Registrar's Signature State sacks

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2004 05061 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** January Juanita Lagana 2004 1:17 P.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner East New Market er 1 Year | If Under 24 Hrs. | 8. 16 Main Street Dorchester 8. Date of Birth (Month, Day, Year) June 13, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6 Say 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 20 F Hours 1951 Maryland 52 216-60-5431 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Dorchester East New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21631 USA 16 Main Street Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Receptionist 11 Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fin and Mental H permit. Pages 1 and 2 should be Department of Health and Mental Iniportant: If Item 27 1s marked the arry injury or other traumatic even 20.56. Olive Ford William Holston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Gene Roland Hoston/Brother P.O. Box 23, East New Market, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) MidShoreCremationCenter 2-2-2004 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gurran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD Parts. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear fails re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician VS resulting in death) /Medical Due to (or as a consequence of) Examiner cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ed bluods 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 🗆 No 1 Yes 2 No 1 Tyes Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Sesidence 6 Other (Specify) Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Anatural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 0 within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical-Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person usse11628 (1) 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

			1 - For Stete Registrer	State of Ma	ryland / D	Certificate of	Death	Re	iene 2004	
	Physicia	an	1. Decedent's Name (First, Middle, La.	st)				2. Date of Deat Month	h Day Year	3. Time of Death
	/Medic			ah Ann Loll	er			Februar		2110 P M
	Examin	er	4a. Facility Name (If not institution, give				or Location of Death	1	4c. County of Death	
			60 Hollingsworth 5. Social Security Number 6. S		(In yrs. last birti	Elkton		8. Date of Birth	Cecil 9. Birtho	place (State or Foreign
	Funeral Director		·217-54-8990 <sup>1</sup>	□M 2X)F 51		rs. Months Days	Hours Min.	July 5,	Year) Coul 1952 Mar	yland
	yland		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	B Marie s	ctor	Maryland Cecil		Elkto	on				1 X Yes 2 No
	or 28	Directo	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What Cou	ntry?
	ath w	ra	60 Hollingsworth			21921			United Sta	
^	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, If a Madical Examiner must be notified at once.	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give		13. Was Decedent of I		o Rican, etc.)	14. Race - Ameri Black, White,	
3	rai', o	þ	3 Nidowed 4 □Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify: Wi	nite
r n	72 hc	etec	15. Decedent's Ed (Specify only highest gra	fucation de completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of wor	king	16b. Kind of Business/In	dustry
V	vithin han	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)				County, Corre	renmont
7	Hygie Hygie ther 1 int, II	e Co	12 17. Father's Name (First, Middle, Last)		F	Administrat		ne (First, Middle, M	County Gove Maiden Sumame)	rimenc
5	d be ental ced o	To Be	Edward Vincent Jo				Elanda F	velyn Br	unnev	
<u></u>	shoul nd Me mark mark	Ĕ	19a. Informant's Name/Relationship (		19b.	Mailing Address (Street	·		City or Town, State, Zip	Code)
Ξ	alth a 27 is r trau		Erica L. Loller/	Daughter	722	2 Adams Str	eet, Art.	1, Hobo	ken, New Je	rsey 07030
Ď,	s 1 a of Hea item othe	1	20a. Method of Disposition		20b. Place of	Disposition (Name of			20c. Location - City or To	
2	Page nent c int: if iry or		1 XBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify			r, crematory or other pla 1 Manor 1 Park	12,	4 1	Elkton, Mar	yland
<u> </u>	ermit. epartn nports ny inju	1	21. Signature of Funeral Service Licer	See   .		22. Name and Addre	ess of Facility  for Fune			
_	20E # 8		- Dones &	Huke	)	103 W. Sto	ckton Str	eet, Elk	ton, Maryla	nd 21921 Approximate
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line	ne death. Do n	ot enter the mode of dyl	ng, such as cardiac	or respiratory arre	est,	Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Von-S	Smell	Coll Lu	ng Cunci			
	Examiner			Due to (or as a	consequence o	1):	0			
7		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence o					
	cuted nd ransit	Examiner	cause. Enter underlying Cause (Disease or injury that initiated events	c.						
Š.	ficate be executed physician and as the burial-transit	EX	resulting in death) Last	Due to (or as a	consequence o	f):				
00/00	physics the t	edicai		d					1	
<b>Y</b>	certifi Iding Ise as		IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of delive	erv
9	death a atter d for u	ician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti		3 □ Ectopic pregnanc 5 □ Other (specify) _	у		Month	Day Year
į	t the by the tacher	Physi	9 Unknown	9□ Unknown						
ן מאין ר	The law requires that the death certi ate has been signed by the attending page 2 should be detached for use a	è	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying cause given	ven in Part I.		acco use contribute to the second sec	ne cause of death?
5	w requ	iete						24a. Was ar	24b. Were auto	psy findings available mpletion of cause of
ב	The la te has age 2	Completed						autopsy perform 1 ☐ Yes 2	ned2 death?	impletion of cause of
<u> </u>	ian: '	0	25. Was case referred to medical				26. Place of Dea	th (Check only one		
>	nysici nis ce direc	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 🗆 ER/Out	patient 3 DOA	ner: 4 ☐ Nursing H	ome 5 Reside	nce 6 □Other (Specif	y)
5	ling Pt n. After th funeral	ertification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Ti	jury Wo	ryat rk?  Yes 2 ∐No	28d. Describe ho	w injury occurred	
2	Attenc death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined		y - At home, far	m, street, factory, office	1.00 2.0,10	28f. Location (Str	reet and Number or Rura	l Route Number,
2	al or after after Direction by	erti	4 ☐ Homicide	building, etc.		,,		City or Town	, State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	edical C			xamination and				use(s) and manner as si ite and place, and due to	
	To the within To the comple	Me	29b. Signature and title of gentiller	1/0		29c. Licens	se number	29	d. Date signed (Month,	Day, Year)
			> /// AG	fel		D	22 6 2	5	2/10/04	
	10		30. Name and address of person who Martha Hostery	Completed cause of dea	th (Item 23a) (1	Type, Print) U. High ST.	#104.	Elkton	u MO a	1921
	Sta Registr	- 1	31. Date filed (Month, Day, Year)	7 2004 Registrar	Signature	M. Brasto	8		/	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05063 For State Registrar AMEND#12+19aper:INF2/12/04,BW,McCo Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death February I, 2004 **Physician** LELAND DALE MINNICK 2:58

, or items 23a or 28a-f show aminer must be notified at

/Medica Examine

**Funeral** Director

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than ' injury or other traumatic evant,

Physician /Medical Examiner

> physician and the burial-transit the certificate has After this c within 24 hours after death.
>
> To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

i e e e e e e e e e e e e e e e e e e e										
4a. Facility Name (If not institution	ity Name (If not institution, give street and number)  4b. City			4b. City, Town, or Location of Death Bethesda				4c. County of Deeth		
Suburban Hospital		Bethe	ontgor					nery		
5. Social Security Number 229-30-8614	6. Sex 7. Ag	e (In yrs. last birthda 75 Yrs	Months Da		24 Hrs. Min.	8. Date of Bird (Month, Da June 16	th y, Year) 5,192	28 7	Birthplace (State or Foreign Country) Virginia	
Usual Residence of Decedent										
10a. State 10b. Count	•	10c. City, Town or Rockvil							10d. Inside City Limits	
Md. Mont	gomery					1 XYes 2 No				
10e. Street and Number			10f. Zip Cod	de			10g. Citi:	zen of Wha	t Country?	
5903 Crawford	Drive			20851		J	Unite	ed Sta	ates	
11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Decedent If Yes, specify (	of Hispanic Or	igin? (Spe	ecify Yes or No	-		American Indian, White, etc.	
1 ☐ Never Married 2 Ma 3 ☐ Widowed 4 ☐ Divorce		1 ☐ Yes 2 █ No Specify:				Specify: W				
15. Decede	nt's Education	16a. De	cedent's Usual Oc	ccupation			16b. Kir	nd of Busin	ess/Industry	
(Specify only high) Elementary/Secondary (0-12)	est grade completed)  College (1-4or t	(G.	ive kind of work do a. DO NOT use re	one during mos stired)	st of work	ng	U.S.	Gove	rnment	
11	00.10g0 (1.10.1)	Prin	iter				Prin	nting	Office	
17. Father's Name (First, Middle	, Last)			18. Moth	er's Name	(First, Middle,	Maiden	Sumame)		
Russell Golder	n Hussey			E11a	a Bla	nche Mi	innic	:k		
19a Informant's Name/Relation Hallie Pearl M	ship (Type, Print)	19b. Ma	ailing Address (Str	reet and Numb	er or Rura	I Route Numbe	er, City or	Town, Sta	te, Zip Code)	
-Pearl Minnick	(Wife)	590	3 Crawfo	rd Dri	ve Ro	ckville	e, Ma	1. 208	351	
20a. Method of Disposition	_	20b. Place of Dis	sposition (Name o	mineral i		ate	20c. Lo	cation - City	y or Town, State	
1 X Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (			Branch Ce		Feb. 200		Dav	ton,	Va.	
21. Signature of Funeral/Service	-	00	22. Name and Ad	ddress of Facili	ty DeV	ol Fune			74.	
The Xa	UNXO	JUL							Md. 20877	
23a. Part1. Enter the disease, of	or complications that caused	the death. Do not							Approximate	
Immediate Cause (Final disease or condition	it only one cause on each li Broncho	ne. Pneumonia	<b>a</b>						Interval Between Onset and Death 2 Weeks	
resulting in death)	Due to (or as	Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Respirat	b. Respiratory Infection								
	Due to (or as	Due to (or as a consequence of):								
triat initiated events	0.	c. Chronic Obstructive Lung Disease								
resulting in death) Last	Due to (or as	a consequence of):								
	d.									
IC CEMALE.							- 1			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						23d. Date of de Month			delivery Day Year	
Part II. Other significant condit	ions contributing to death b	ut not resulting in the	a underlying cause	given in Part I	l,	23e. Did to	bacco us	se contribut	te to the cause of death?	
Coronary Arter	y Disease								Probably 4 Unknown	
Hypertension							rmed?	prior deat	e autopsy findings available to completion of cause of h?	
	al			26 Diag	of Doort	autop perfor 1 Tes	rmed? 2 <b>X</b> No	prior deat	e autopsy findings available to completion of cause of h? Yes 2 \( \text{No} \)	
Hypertension  25. Was case referred to medice examiner? 1 \( \) Yes 2\( \overline{\pi} \) No	al Hospital: 1 🔀 Inpatie	ont 2□ER/Outpai	tient 3 DOA			autop perfo	rmed? 2 <b>X</b> No	prior deat 1 🔲	to completion of cause of h? Yes 2 No	

State Registrar

Certification

Medical

1 🔀 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 04 2004

5 Pending investigation

6 Could not be determined

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Alberto Rotsztain M.D. 6116 Executive Blvd. #155 Rockville, Md. 20852 Docker

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

18612

1 ☐ Yes 2 ☐ No

Md.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 2001 05064 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** HUMME FEBRUARY MILLER 2004 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Balt. Baltimore Hospital Hopkins If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months 1□<sub>X</sub>M 2□ F 299-60-8986 39 Nov. 25, Director 1964 Ohio Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ral', or items 23a or 28a-f show Executive nust be notified at X□Yes 2□No **Funeral Director** Maryland Montgomery Silver Spring 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 16804 Harbour Town Dr. 20905 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or ite any njury or other traumatic avent, the Medical Exercities any njury or other traumatic avent, the Medical Exercities and 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/☐ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Consultant Public Relations 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Paul Miller Rose Marie Hummel ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kyung Cho-Miller- Spouse 16804 Harbour Town Dr. Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 02/06/2004 4 ☐ Donation 5 ☐ Other (Specify) Dagsboro, DE 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave. Silver Spring, MD 20904 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA 2 WEEKS FUNGAL /Medical Due to (or as a consequence of): **Examiner** 0 MONTHS LYMPHOMA NON- HODGKINS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. physicien Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown signed t I be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 has autopsy certificate 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 3□ DOA Medicai Certification: To 2 ER/Outpatient Sign 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Natural 2 Accident 5 Pending investigation 2 🗌 No death. 1 Tes thours after death.

uneral Director: A

sly filled in by the fu 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D58902 MD 2,2004 20 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 21287 JOHNS DAVID WANG, MO HOPKINS HOSPITAL, GOO NORTH WOLFE STREET, BALTIMORE, MARYLAND 31. Date filed (Month, Day, Year) FEB 0 4 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Physic /Med Exam Funera

Directo

parmit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiana. Important: If tem 27 is marked other than "natural", or items 23s or 28s-f show any linipry or other traumatic event, the Medical Examiner must be notified at any linity or other traumatic event, the Medical Examiner must be notified at any longs.

Baltimore, Maryland 21215-0020

Physician /Medical Examine

within 24 hours aftar daath.

To the Funeral Director: Aftar this cartificata has baan signed by tha attanding physician and complataly fillad in by tha funaral director, paga 2 should ba datached for usa as tha burial-transit To the Hospital or Attanding Physician: The law raquiras that tha death cartificate be axecuted

Division of Vital Records, P.O. Box 68760,

ANNE	MEN	DELSON					onth IUARY	Day 24, 20	Year 104	9:55 A	
4a Fecility Name (If not institution	, give street and number	r)			4b. City, Town				y of Death		
ROCKVILLE NURSI					ROCKVI			MONTGO	MERY		
5. Social Security Number 116-14-9655	6. Sex 7. A	ge (In yrs. last birl		f Under 1 Year Ionths Days		Min. (M	ate of Birth fo <i>nth, Day</i> , 4/192	Year) 5	9. Birthpli Count NEW Y	ace <i>(Stat</i> e or Fo try) ORK	
Usuel Residence of Decedent  10a. State 10b. County		10c. City, Towr	or Locati	ion					10	Od. Inside City Li	
	MEDI									1 🕅 Yes 2 🗆	
MARYLAND MONTGO Oe. Street and Number	MERY	ROCKVIL		10f. Zip Code			10	g. Citizen of	What Count	rv?	
303 ADCLARE ROA	D								777141 0 0 0 1 1 1	.,.	
1. Marital Status	12. Was Deceden Armed Forces	t Ever in U,S.	13. Was	20850 Decedent of F	dispanic Origin	n? (Specify Y	es or No-	.S.A.	ce - America	an Indian,	
1 ☐ Never Married 2 ☐ Marri 3 🎇 Widowed 4 ☐ Divorced	? [No :	If Yes, specify Cuban, Mexican, Puerto Rid					Black, White, etc.  Specify:  WHITE				
15. Decedent		16e.	Decedent	's Usual Occup	ation	fundina	1	6b. Kind of B			
(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO	d of work done NOT use retire	d)	working					
	5+	TEA	CHER				P	UBLIC	SCHOO	LS	
7. Father's Neme (First, Middle, I	.ast)				18. Mother's	Name (First	, Middle, M	aiden Surnar	me)		
SIMON		SELMAN			MIRIA				OSENB		
19a. Informant's Name/Relationsh			_	ddress (Street				•		,	
JONATHAN MENDEL	SON/SON				RRACE,	Ţ	-			ND 2090:	
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐Removal from State	20b. Place of cemeter		on (Name of ory or other pla	ce)	Dat	e 2	0c. Location	- City or Tov	m, State	
4 ☐ Donation 5 ☐ Other (Sp.		MT. LEE	BANON	CEMETI	ERY	1/29/	'04 A	DELPH	I, MAR	YLAND	
21. Signature of Funeral Service L	icensee			ame and Addre		DIT MINIM	COTAT	C11 8 7377	T (2 T)	57.63	
/ (Imanda	Ludouro	,	11170	ROCKV	ILLE P	IKE, R	OCKVI	LLE, M	D 208	52	
23a. Part1. Enter the disease, shock, or heart failure. List	complications that cause	the death. Do n						The second second second		Approximate Interval Betweer	
diseese or condition resulting in death)	a. PARKINS	Due to (or es a c		ice of):					 		
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or es e c	onsequen	ce of):							
that initieted events resulting in death) Last	d	Due to (or as a c	onsequen	ce of):							
Part II. Other significant condition										the cause of de	
DEMENTIA, HYPER	TENSION, AT	HEROSCLE	ROTIO	CEREB	ROVASCU	JLAR	1 🗀 Yes	2 ₹ No	3 Probe	ably 4 ☐ Unki	
DISEASE, GASTRO	STOMY TUBE	MY TUBE MALFUNCTION					24a. Was an autopsy performed?		24b. Were autopsy findings available prior to completion of cause of death?		
							1 🗆 Yes	2 <b>X</b> ) No		Yes 2□ No	
25. Was case referred to medical					26 Place of	Death (Che					
examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2□ER/Out	natient 1	BO DOA Oth				ce 6 □Oth	ner (Specify)		
27. Menner of Deeth	28a. Date of Injury	ury 28b. T	ime of	28c. Injur	וונוטוו באַר			injury occur			
1 Natural 5 ☐ Pending 2 ☐ Accident investig	ation (Month, De	ay rear) In	jury		k? Yes 2∐No						
3 Suicide 6 Could n 4 Homicide determine	ot be ned 28e. Plece of In building, e	28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)					3f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1	Physician: To the best examiner: On the basis of and manner st	of examination end	death occ	curred et the tir igation, in my o	ne, date and p pinion, death o	place, and du occurred at th	e to the cau ne time, dat	se(s) and ma e and place,	anner as sta and due to t	ted. the cause(s)	
29b. Signeture and title of certifier	11/			29c. Licens	e number	/	290	d. Date signe	d (Month, D	ey, Year)	
· 401	M	$\bigcirc$		Do	0594	99	TAN	TILADV	20 20	10 /	
30. Neme end address of person y	no completed cause	death (Item 23e) (	Type Prin		7 . 1	-1	U Al	NUARY	<u> </u>	104	
MARY CALLSEN, M		XECUTIVE			, ROCKV	/TITE	MD 20	1852			
31. Dete filed (Month, Day, Year)		rer's Signeture	LULIVE	1		وظيني	TID Z	1012			
FEB 02	2004	review /	9	spark	2						

Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05066 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:30 P M January 28, 2004 CAROL MELICHAR CYRIL /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5/17/1925 Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Months 1**⊠** M 2□ F 78 Yrs. Pennsylvania Director 193-16-3105 Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is markad other then "natural", or Itams 23a or 28a-1 show any hiury or other traumatic event, the Medical Eparamet must be notified at once. 1 ☐ Yes 2 ☑ No Director Falls Church Virginia Fairfax 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7434 Tillman Drive 22043 USA by Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. Armed Forces:

1 Nes 2 No
If Yes, Give 1942Year or Dates: 1966 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital Corpsman U.S. Navy 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame). Be John Melichar Kathryn Badurik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Melichar (wife) 7434 Tillman Dr. Falls Church, Va. 22043 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Cremation Center Chantilly, Va. 2/3/04 21. Signature of Funeral Service Lieensee 22. Name and Address of Facility Murphy Falls Church Funeral Home 1102 W. Broad St., Falls Church, Va. 22046 Janne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner CINOMA CAR KUN G Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physicien IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 2 TFetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, funeral director, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 'es 2 No 1 Yes or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ↑ Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ANatural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 1-27660 M.D. 30. Name and ad it is of person who completed cause of death (Item 23a) (Type, Print) ROCKUILLE, MD20852 11119 ROCKVILLE PIKE GOSWATTI M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 4 2004 oaks Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 For State Registrar 05067 Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) **Physician** 6:30 28, 2004 January Tankeo Mechu-Arrth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Charles 2360 Mail Coach Court Waldorf If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F 215-96-5877 86 10, 1917 Thailand Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or the say injury ogother trauments. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2X No Directo Maryland Charles Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20602 2360 Mail Coach Court USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Asian þ 3 ☐ Widowed 4 🖔 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Keaw Sangkorn Srima Sangkorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pattana Wachrathit - Daughter 2360 Mail Coach Ct, Waldorf, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 8, 2004 Alexandria, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) Everly Crematory 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service License ichelo M01241 3035 Old Washington Road, Waldorf, MD 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ongestive Physician /Medical Due to (or as a consequence of): **Examiner** noon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ 🗖 28a. Date of Injury (Month, Day Year) 27. Manner of Peath completely filled in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After . Injury 5 Pending 1 Yes 2 No death. 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Contitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of confider 1/28/0 3328 Old Washington 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ED JOS CIM FYTH DOLD adevi Surusam. LYVIDER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 02 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05068 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4, 2004 February 9:40 Phyllis A. McWilliams /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Germantown Montgomery 19057 Partridge Wood Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign
Country) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🖾 F Yrs April 5, 1929 74 Maryland Director 579-38-0619 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show majoriny to gither traumatic event, the Wedical Examinar must be could also some. 1 ☐ Yes 2 No Director Germantown Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20874 USA 19057 Partridge Wood Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: by 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alberta Wilkinson Richley Abell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19057 Partridge Wood Drive, Germantown, MD 20874 Christine Wrenn/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 6 1 

Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 2004 Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) etastatic **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, the attending physicien Physiclan/Medical IF FEMALE . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Day in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 21 ☑ No 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 X Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed (es 2) certificate 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 x Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funerel Director: in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) ro the 29c. License number 29b. Signature and title of certifier 3 JEAN Ry person who com leted cause of death (Item 23a) (Type, Print) 30. Name and address 9 Meadow 20407 Seneca 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 06 FEB Registrar 2004

State of Maryland / Department of Health and Mental Hygiene 2004 05069 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:15<sup>AM</sup> 28, 2004 CECELIA O.

4a. Fecility Name (If not institution, give street and number) MCAFEE January. /Medical 4c. County of Death 4b. City. Town, or Location of Death Examiner Hyattsville
If Under 1 Year | If Under 24 Hrs. Prince Georges Sacred Heart Home 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2√☐ F Ohio Director 369-22-0968 Usual Residence of Decedent 92 October 4, 1911 filed withIn 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or Itams 23a or 28a-f show aminer must be notified at 1 ☐ Yes 2 ☑ No Director Pr. Georges Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5805 Queens Chapel Road 20782 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withlinent of Health and Mental Hygiene. ent: if Item 27 Is marked other then ury or other traumatic event, the M 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname, 17 Father's Name (First, Middle, Last) Be Leonora Mendenhall Otto Zonner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1020 Springvale Rd, Great Falls, VA 22066 Rev. Franklyn M. McAfee (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of the Important: If Ite any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairfax Memorial Park | 2/4/04 Fairfax, Virginia 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Murphy Falls Church Funeral Home 1102 W. Broad St., Falls Church, VA 22046 /mun 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death SEPSIS SYNDROME Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed as the burial-to Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ţo in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death P.O. | Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by STATUS POST GANGALINE HYDRA DOW. 1 Yes 2 No 3 Probably 4 Unknown FRIAUN 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy CARE performed' - COMFORT Yes ILING 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? After 5 Pending 1/2 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature, and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 04 Registrar

State of Maryland / Department of Health and Mental Hygiene 05070 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 31, **Physician** Mary Lee Mannina 2004 9:46AM /Medical 4a. Facility Name (If not institution, give street and number)
4517 Hornbeam Drive 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplece (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1 □ M 2 □ F 224-18-4377 83 July1,1920 Virginia Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10b. County or 28a-f show Examiner must be notified at 1X Yes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t 4517 Hornbeam Drive 20853 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give A Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married ٥ 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 Widowed 4 Divorced "natural" Completed the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Administration Montgomery Co. 12 Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental H tam 27 is marked off other traumatic ever Pages 1 and 2 should be Josiah David Shupe Ella Kate Goodman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paul D. Mannina -son 1829 Tufa Terrace Silver Spring, Maryland 20904 : If itam 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition to 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or permit. Page Department of Important: If any injury or once. Metropolitan Crematory 2/6/2004 Alexandria, Virginia 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705 21. Signature of Funeral Service Licensee Donald V geward 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician Melanoma 4 months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) physician Box 68760. Physician/Medical the IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 🗌 Yes 2 🔽 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 XNo Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tniury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D23600 February 2, 2004 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Bruce R. Kressel, M.D. 5480 Wisconsin Ave., #214 Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks 2004 FEB 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05071 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 08 44 W **Physician** MACHWISTY PETER runuate 2004 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Benedros Monteouty If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Dey, Yeer) Mar. 6, 1949 7. Age (In yrs. last birthday) 6. Sex 5 Social Security Number **Funeral** Days **№** M 2 F Mar. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f ahow event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Bethesda Director MD. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 20817 USA 6214 Crathie Drive permit. Pages 1 and 2 should be filed within 72 hours atter death v Department of Health and Mental Hygiene.
Importment: If item 27 is marked other then "natural", or Items 23s any injury oc other traumatic event, the Medical Examinar mans once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 Ø Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Health Psychologist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nancy Mandel Larry Malawista 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9421 Thrush Lane, Potomac, MD. 20854 Kerry Heilbron/Ex-wife Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □ Removal from State Mt.Comfort Crematory 1/29/2004 Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address & Eastly Gawler's Sons Inc., 5130 Wisc. Ave., NW., Washington D.C. 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate HAUGUE = ASOMY KARTION Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SULCIUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical SE IF FEMALE: esn' 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 1 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by BLAUCUAR DISENSE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? 1. Yes 2 □ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 70 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: OF TY HANGERO - SUZIA 5 Pending investigation 1 Natural 1/22/04 1 Yes death. 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à hours after -topics GRY CRATHE LAND, BETHEON MO within 24 hours a To the Funerel E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Sedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check of and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number and title of certifier 29b. Signature travery ve, 2004 015736 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cher I mangalis me Was factories Piers, focusius Mo 20872 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Beneva FEB 0 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygienes 05072 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yeer **Physician** Florence Irene Magers February 2004 3:22 P /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🖾 F 91 4,1913 VA Director Jan. 212-68-3698 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ▼ Yes 2 No MD Montgomery Gaithersburg Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 United States 105 Oakton Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify: δ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11 permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygis Important: If itam 27 Is marked other any injury or other traumatic svent, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Casper Russell Ritenour Mary Catherine Marston ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia E. Oland / Daughter 103 Woodland Road, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition injury or February 6 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer 21. Signature of Funeral Service Monsee RACY A. Park Drive, Gaithersburg, MD 20877 uver 23a. Part 1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Heart Disease /Medical Due to (or as a consequence of) Examiner Myelodysplasia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Acute Renal Failure the attending physician and Due to (or as a consequence of): Physician/Medical Congestive Heart Failure use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 ☐ Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 20 No 1 🗌 Yes 2 🗆 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death uneral Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours of To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signam and title of certifier Moserm V -February 2, 2004 devouis D47330 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edmonston Drive, Rockville, MD 20852 50 W. Thomas V. Joseph, M.D.,

DHMH 17 Rev 1/2001

State

Registrar

EB 04

2004

31. Date filed (Month,

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05073 For State RegistragNFND#23aIIperMD2/6/04, BMW, McCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 200115 1655 /Medical 4c. County of Deeth Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** M ce ster Counte TOSPI 1 Year | If Under 24 Hrs/ 8. Date of Birth Month, Day, 7/12/1 9. Birthplace (State or Foreign Country)
Wash., D.C. 5. Social Security Number 5 7 8-14-6769 6 Sax 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 82 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h Count 10d. Inside City Limits 28e-f shov treumatic event, the Medical Examiner must be notified at Worcester Ocean City YEYes 2 □ No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21842 USA 601 Bayshoæ Drive#18 Items 23e Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 194 16 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1942 1 Never Married 2 Married Maryland 21215-0036 6 1 ☐ Yes 2 No White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ? nent of Health and Mental Hygiene. snt: If item 27 Is marked other then " College (1-4or 5+) Elementary/Secondary (0-12) Auto Dealer Self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Nick Mantzouris Helen Kalavritinos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Bayshore Drive #18 Ocean City, Md21842 Lillian Mantzouris/Wife tment of Health a other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crownsville Vet's 1/28/04 Crownsville, Md 21. Signature | Funeral Service Lie nsee PHILIP OD: RINALDI FUNERAL SERVICE, P. A Impo eny in 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician MUN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of): the death certificate be Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) o. 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records. 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Be Completed 6 MUOS it 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DQA 4 Nursing Home 5 Residence 6 Other (Specify) ð this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Hospitel or Attending 5 Pending investigation 1 Matural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier

Registrar

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Mant 20411.

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CUASTAL HIGHLAY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

32. Registrar's Signature

31. Date filed (Month, Day, Year)

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			For State Registrar	State of Maryland	/ Depar	tment of ificate of	Health an	nd Mental	Hygiene		05074
)	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last ENNIS ANGLE /I 4a. Facility Name (If not institution, give	lummert	4		or Location of [	2. Date of Month	CLT Y 2	County of Death	
	Funeral Director		220-28-8899			Hage If Under 1 Year Months Days		Hrs. 8. Date (Month	of Birth h, Day, Year) 4, 193	Washing  9. Birth Con Mar	ton pplace (State or Foreign intry) yland
	h the Maryland r 28a-f show	Director	Usual Residence of Decedent           10a. State         10b. County           MD         Washingt           10e. Street and Number		rpsbur	g 10f. Zip Code			10g. Cit	izen of What Co	10d. Inside City Limits 1 ☐ Yes 2€ No
30	be filed within 72 hours after death with the Maryland Hygione. d other then "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at	by Funeral D	6702 Dam #4 Road  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ĀNo If Yes, Give Year or Dates:	ì	21782 as Decedent of Yes, specify Cu		n? (Specify Yes of Puerto Rican, etc.		14. Race - Ame Black, White	
Maryland 21215-0036	filed within 72 hour Hygiene. other then "naturel ent, the Medical El	Completed t	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	(Give kii life. DC	nt's Usual Occu nd of work don O NOT use retir patcher	upation e during most o ed)	f working	Ele	ind of Business/lectric U	tility
_	m = 0 5	To Be C	17. Father's Name (First, Middle, Last) Harry Angle Mumm 19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailing	Address (Stree	Margu	erite (S	Snook)	McNamee	ip Code)
Baltimore, M	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		Pamela Lucille M  20a. Method of Disposition  1 Burial 2 Scremation 3 C  4 Donation 5 Other (Specify	20b. Plac cem	e of Disposit etery, crema hsburg	tion (Name of atory or other pl Cremat	ace)	ert, 108	20c. Lc	cation · City or thsburg	own, State
Ball	permit. Deper		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or compshock, or heart failure. List only	lications that caused the death.	16 Do not enter	01 Penr	isylvani ving, such as ca	urdiac or respirat	Hager		Approximate Interval Between Onse; and Death
ij.	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	b	nce of): ひとい M	ONIA.	J. prod	5,7			3) Weks.
3760,	ate be executed hysician and he burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C  Due to (or as a consequer  d							
.O. Box 68	The law requires that the death certificate ate has been signed by the attending phy page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 E	Ectopic pregnan Other (specify)	су			23d. Date of deli Month	very Day Year
Records, P.	w requires that the de been signed by the should be detached		Part II. Other significant conditions co	ontributing to death but not resulting	ng in the und	derlying cause g	jiven in Part I.	_	1 ☐ Yes 2	□No 3□Pro	the cause of death?
_	ian: The law intificate has b ctor, page 2 s	Be Completed	25. Was case referred to medical examiner?				26. Place o	1 Death (Check		prior to death?	topsy findings available completion of cause of
Division of V	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To E	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28 28e. Place of Injury - At home	NOutpatient  Bb. Time of Injury  e, farm, stree	28c. In: W	ury at ork? □ Yes 2 □ No	28f. Local	tion (Street an	ry occurred	ral Route Number,
Ď	Hospitel or A 24 hours after Funeral Directors etely filled in by	Medical Certi	29a. Certifying Ph	building, etc. (Specify)  ysician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, death o	occurred at the	time, date and	place, and due to		and manner as	
	\ \	Me	29b. Signature and title of certifier	_ MD	20) /	0	nse number 4728		C	te signed (Monti	400
6	Sta	ate	30. Name and address of person who of Dr Ig bal  31. Date filed (Month, Par Mean) 2	completed cause of death (Item 2	K H'	. 6 /1	: N	agers	itow.	n Ma	iry land

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05075 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** HARRIET **ESTELLE** MARTIN JANUARY 30, 2004 7:00 P /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) **Examiner** ANNAPOLIS
If Under 1 Year If Under 24 Hrs. ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 6. Sex **Funeral** Days Months Hours 1 □ M 2 😿 F 89 WASHINGTON, D.C. 579-12-3396 OCT 1, 1914 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral', or items 23a or 28a-f shov Exercities must be notified at 1 ☐ Yes 2 ☐ XNo **AVERY** Directo NC BANNER ELK. the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? With 104 TROUT POND LANE 28604 USA deeth Funeral Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages t and 2 should be filed within 72 hours after ☐Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. WHITE Completed by 3 Widowed 4 ☐ Divorced Year or Dates: "netural", er than "netur . I've Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene CASHIER FOOD RETAIL 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be marked WILLIAM R. PRUITT 2 ANNA E. COX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and . Item 27 I STEVENSVILLE, 105 TOWER DRIVE THOMAS MARTIN / SON MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages t Department of H Important: If the any Injury or ot once. 1 ☐ Burial 2 X Fremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/2/04 STEVENSVILLE, MD 4 Donation CHESAPEAKE CREMATION CENTER LLC 21. Signature of Faneral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA. 106 SHAMROCK ROAD CHESTER, MD, 21619 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediete Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of Examiner 3 hours Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. attending physicien Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached Ö 9 Unknown 9 Unknown Division of Vital Records, P. signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ► No 2 ER/Outpatient 2 1 Inpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Intury 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 🗌 Homicide hours after 24 hours a 1 Crtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number cm cm D24336 01 30 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. KENNETH GUMMERSON 2001 MEDICAL PKMY ANNAPOLIS, MD 21401 32. Registrar Signature 31. Date filed (Month, Day, Year) State EB 0 Registrar

Amended #21, nls, 02/10/04, Allegany Co. **Physician** /Medical **Examiner** the Linwood McKer **Funeral** Director 10a. State 28a-f show or other traumatic event, the Medical Examinar must be notified at WV **Funeral Director** or items 23a or Be Completed by permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other traumatic event 2008.

**Physician** 

/Medical Examiner

for use as the burial-transit

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 05076 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death January 21, 2004 6:30 A M Frederick Linwood McKee 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 7. Age (In yrs. last birthday)
7. Age (In yrs. last birthday)
7. Age (No yrs. last birthday)
8. Age (No yrs. last birthday) Reeders Memorial Nursing Home Washington Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1√3 M 2□ F 76 Yrs. 227-22-2208 05-16-1927 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Berkeley 1 ☐ Yes 2√No Martinsburg 10e. Street and Number 12 Thornberry Drive 10f. Zip Code 10g. Citizen of What Country? 25401 **USA**  Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status I Tes, 2 □ No If Tes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: caucasian 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 carpenter college 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Amos William McKee Elsie Rebecca Wingfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Rebecca Graves/daughter 12 Thornberry Drive Martinsburg, WV 25401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ty☐ Burial 2 ☐ Cremation 3 ☐ Removal from State roce Lipens Hour A. Lyckurch 22. Name and Address of Facility \*4 Donation 5 Other (Specify) 1-24-04 Winchester, VA 21. Signature of Funeral Se Omps Funeral Home 1600 Amherst St. Winchester, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lorgneeal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Nursing Home 5 Residence 6 Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Guedenet 21 Wyand Drive, Keedysville, Maryland 21756 / 301-432-2222 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 2 2004

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DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 05077 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 11:31 P M 2, Robert G. Nevitt February 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F 82 Dec. 27, 1921 Washington, DC Director 577-28-9408 Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28s-f ahow permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylar Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, Ita Mudical Examt acritical to myllied an once. 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10307 Duvawn Place 20902 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1941–47 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Utility Company Purchasing Agent/Office Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Israel Nevitt Marion C. Goodrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty W. Nevitt/ Wife 10307 Duvawn Place, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 6 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Washington, DC Rock Creek Cemetery 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failers. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Agonal Aspiration of Gastric Contents Savue rially ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner I or Attending Physician: The law requires that the death certificate be executed attracted to the certificate has been signed by the attending physicien and Director: After this certificate has been signed by the attending physicien and in by the Inneated firector, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Dehydration, Acute Renal Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 X No Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29c. License number 29d Date signed (Month Day Year) 29b. Signature and title of certifier 12 D52261 February 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1517 Hugo Circle, Silver Spring, MD 20906 Alan R. Segal M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 05 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 05078 State
Registrar Amend Item#23bperPHYG8293/1/04 EN Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 0215 AM Donna Jane Nolan 0 26 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Cumber Allegany Sacred Heart land If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director 215-58-7142 43 Aug 25,1960 Maryland Usual Residence of Decedent 10c. City. Town or Location 10a. State 10h County 10d. Inside City Limits or 28a-1 show the Medical Exeminer must be notified at 1 Yes 2 No Maryland Allegany Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 820 Bishop Walsh Road USA "natural", or Itema 23a. 21502 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James V. Mallozzi Rita S. Helmstetter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick S. Nolan-Husband 820 Bishop Walsh Road, Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan 29,2004 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State LaVale, MD Rest Lawn MemorialGardéns \* 4 ☐ Donation 5 ☐ Other (Specify) A. Signature of Funeral Service Liceg 22. Name and Address of Facility Hafer Funeral Service, PA 23a. Part 1. Enter the disease or complications that assed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximately 150.2 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician Due to or as a consequence /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Tue to (or as a consequence of Examiner been signed by the attending physician and should be detached for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🙀 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2Z No ospital or Attending Physician: I hours after death. uneral Director: After this certifical ly tilled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient ٩ 3□ DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier (Check only one) and manner stated. 29b. Signature and time of certified 5 30. Nam and address of person who completed cause of death (Item 23a 177, e, Print) nds SETON DRIVE Comberland, Hd. 21502 Dr. John Mehanna 902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 9 2004 Registrar

DHMH 17 Rev 1/2001

			1 - For State of Maryland / De Registrar	epartment of Health and M Certificate of Death	Mental Hygid	ene 2004	05079
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici: /Medic		Ida Pauline Olcese		Month 1	Day Year 3.1 2.004	8:15a <sup>M</sup>
i i	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			William Hill Manor	Easton		Talbot	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Davs Hours Min.	8. Date of Birth (Month, Day, )	Year) Country	e (State or Foreign )
	Director		Usual Residence of Decedent		4-10-19	920   PA	
	/land		10a. State 10b. County 10c. City, Town of	r Location		10d	. Inside City Limits
	Man,	ğ	MD Talbot Easton				1 X Yes 2 □ No
	th the or 28; e.n.d	le	10e. Street and Number	10f. Zip Code		g. Citizen of What Country	?
	th wil	al	501 Dutchmans Lane	21601		USA	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural; or tlems 23a or 28a-f show int, I'te Medical Exartaine must be neutilied al	by Funeral Directo	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Wildowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give A Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> <li>□ Yes 2√√ No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - American Black, White, etc SpecifyNhite	
215-0036	2 hou atura cal E	ted	15 Decedent's Education 16a, D	ecedent's Usual Occupation	16	6b. Kind of Business/Indus	stry
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2	ad wit giene erthu	Con		cretary		University	OI PA.
ב	d a b y	Be		18. Mother's Name	e (First, Middle, Ma	aiden Sumame)	
Maryland 21	Mer Mer arke	ဥ	Santo Allegra			01-1-T-1-01-1-T-0	
Z Z	2 4 2 2			lailing Address <i>(Street and Number or Rure</i> 132 Pea Neck Rd.			
ė,	ss 1 and of Health item 27 r other t		20a Method of Disposition 20b. Place of D	isposition (Name of		0c. Location - City or Town	
altimore,	Pages nent of int: If it iry or o		cametery	crematory or other place) of Crematory 2-3	-04 De	over, DE.	
≣	permit. Page Department of Important: If any injury or once.		21. Signature / Funeral Service Licenses	22. Name and Address of Facility	_	1 50	
ñ	Den grand		Varyer & Leonard	R. Carroll Hurle			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause of each line.	enter the mode of dying, such as cardiac	or respiratory arres	st, A	oproximate tervai Between
	Physician		Immediate Cause (Final disease or condition	lia		0	nset and Death
	/Medical		resulting in death)  a. Due to (or as a consequence of)				Julys.
	Examiner		Sequentially list conditions.				
	si ad	lner	Sequentially list conditions, if any, leading to immediate cause. Einter Underlying Cause (Disease or injury				
	and Ftran	Examin	that initiated events resulting in death) Last Due to (or as a consequence of)				
3/60,	cate be executed physician and the burial-transit	alE					
28	death certificate be executed e attending physician and id for use as the burial-transi	edlcal	0.				
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ecords, 1	law requires that the de as been signed by the a 2 should be detached f	ρχ	Part II. Other significant conditions contributing to death but not resulting in the Cuch ruras cular desease	e underlying cause given in Part I.	23e. Did toba	cco use contribute to the c 2 DNo 3 ☐ Probabl	ause of death? y 4 □Unknown
<del>ဂ</del>	w requir	lete	Dispetes		24a. Was an	24b. Were autopsy prior to compl	findings available
	iician: The lav certificate has rector, page 2	Completed	Charles Samuel II. 1	a de O como co	autopsy performe 1  Yes 2	prior to complete death?  One of the complete death?	
	an: ] tifical tor, p	BeC	25. Was case referred to medical	26. Place of Death	(Check only one)	<u> </u>	2110
	d is	To B	examiner? 1   Yes   2   No   Hospital: 1   Inpatient 2   ER/Outpa	ttient 3 DOA Other: 4 X vursing Ho	me 5 Residenc	ce 6 □Other (Specify)	
	ding Ph h. After th funeral		27. Mapner of Death 28a. Date of Injury 28b. Tim (Month, Day Year) Injury Injury 1,000 Injury 1		28d. Describe how	injury occurred	
<u>o</u>	E ta :: e	catle	2 Accident investigation	M 1 Yes 2 No			
DIVISION	after death after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	City or Town,	et and Number or Rural R State)	oute Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, of (Check only 2 Medical Examiner: On the basis of examination and/or				
	the H nin 24 the F nplete	ledical	one) and manner stated.				
	Mit To mit	Σ	29b. Signature and little of certifier	29c. License number	1 290	d. Date signed (Month, Day	, rear/
•			fler fur der -	Delay /	/	1/31/07	
			30. Name and address of person who completed cause of death (Item 23a) (Ty  AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	Washers ton 5	t East	on m D 21	601
	Sta	te	31. Date filed (Month, Day 1992) A 200 32. Regisfar's Signature				
	Registr		LER A S STATE OF THE STATE OF T	Aced.			

State of Maryland / Department of Health and Mental Hygiene 2004 05080 Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 2004 **Physician** 1:49 AM OLKON Anna /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) Feb. 13, 1918 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2∰F Days Hours Poland 220-82-4854 85 Yrs Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene important: if Item 27 is marked other then "natural", or Items 23a or 28a-1 show eny injury or other traumatic event, the Medical Experiment for multified at once. 1√ Yes 2 No MD Wheaton Montgomery Director 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 20902 2213 Reedie U.S.A. Drive Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2☐No fYes, Give X 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (unknown) Celia Menachim Mendel Marcus 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2914 Schoolhouse Circle, Wheaton, MD 20902 Mark Olkon / son 20a. Method of Disposition

+D Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb. 2, 2004 Jerusalem, Israel Eretz Hachaim Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Line Torchinsky Hebrew Funeral Home, Inc. 254 Carroll St., NW Washington, DC 20012 23a. Part1. Enter the disease, or semplications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Atheros lerotic Cardiovascular Disease Years Pnysician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. the attending physician hed for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year signed by the at d be detached for 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No certificate 1 Yes Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? X 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 XDOA 2 this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 XNaturai To the recognition 24 hours after death.
To the Funeral Director: Af М 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 29, D0043539 1500 Fonest Glen Rd. 30. Name an ress of person who completed cause of death (Item 23a) (Type, Print) Holy Cross Hospital, Silver Spring, MD Raymond M. White, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 2 2004 onks Registrar

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 20 **Physician** 2 Harry K. Oh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Rockville Montgomery Hebrew Home of Greater Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1**X** M 2□ F 68 3, 1935 **Director** 557-50-8211 Oct. Korea Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or itams 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 😾 No Director Rockville Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or itams 23e any injury or other traumatic event, If a Medical Exacting in marked once... 20852 6121 Montrose Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specity: If Yes, Give Year or Dates: Specify: Asian ģ 3 ☐ Widowed 4 1 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Electrical Consultant Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Not Available Not Available ္င 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Glades Way, Huntington, NY 11743 Richard C. Oh/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 4, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 2004 M01346

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses 125 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary /Medical Due to (or as a consequence of): \_ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Lipury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and Due to (or as a consequence of): attending physicien a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 90 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? certificate ! 1 Yes 2₽No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 2 ŏ his funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification; After Division the Hospitel or Attending 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funerel Direct 4 - Homicide Letifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Uraza 1:44907 200 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Consuello Alvarez, M.D. 6121 Montrose Road, Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature racks FEB 06 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05082

							$\mathcal{C}$	ertific	cate of	Death	1	F	Reg. No.	07	0	0002
			1. Decedent's Name (First, Mi	ddle, Las	st)							2. Date of Dea	th		3. Tir	ne of Death
	Physici		Evo Tourigo	Owar	300							January	7 25 2	Year 004	5:	20 AM
. 10	/Medio		Eva Louise 4a. Facility Name (If not institu	tion, aive	ige street and ni	ımber)				4b. City, To	own, or Lo	ocation of Death	4c. Count			
2	Examir	ıer	***	_			~~+~-			TTo our			F.7 3- 1		_	
			Beverly Heal 5. Social Security Number	6. S		7. Age (In y	re last birtha	1 lava If U	nder 1 Year	Hage:	LS TO 24 Hrs.	√N 8 Date of Birth	_wasni	ngton	COL	inty tate or Foreign
	Funeral				_M 2 <mark>1</mark> 2 F		87 Yrs	Mon			Min.	(Month, Day	Year)	Cour	try)	ale or roreign
	Director		220-05-6124 Usual Residence of Decedent				· · · · · · · · · · · · · · · · · · ·		ŀ			April 3	1916	Mar	ylar	1a
	pug s		10a. Stete 10b. Cou	ntv		10c.	City, Town o	r Location						1	0d. Insid	de City Limits
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	F or 2	Ö	10e. Street and Number						. Zip Code			1	0g. Citizen of	What Cour	try?	
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	eep E	Funeral Directo	11. Marital Status		12. Was Dec Armed F	edent Ever in orces?	U,S. 1	3. Was D	ecedent of I	Hispanic Or oan, Mexica	igin? (Spon, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,		ın,
0	after or it		1 ☐ Never Married 2 🔀 M	larried		2X No			s 2∐XNo					w. Whi		
2	ours E	<u>ā</u>	3 ☐ Widowed 4 ☐ Divord	ed	Year or I	Dates:			20 20.10	- Cpc on y			Орвен	у.		
<u>ب</u>	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or items 23a or 28a-f ehow ant, the Masical Examiner must be notified at	Completed	15. Deced (Specify only hig	lent's Ed	ucation	)	16a. De	cedent's	Usual Occu	pation during mos ed)	at of work	ina	16b. Kind of B	lusiness/Ind	dustry	
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7	d the	6	12				Hon	nemak	er				Persona	al Res	side	nce
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<u>ज</u>	Id be enta	To B	Wilmer G. Pri	ce						Eva	Amel	ia Plum	mer			
چ	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "netural", or items 23a or 28a-1 ehow transatic event, the Masteel Examiner must be notified at		19a. Informant's Name/Relation		ype, Print)		19b. M	ailing Add	iress (Stree	t and Numb	er or Rura	ai Route Number	r, City or Town	, State, Zip	Code)	
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ď,	1 end 2 Health em 27 l		20a. Method of Disposition	90/1	abana	20b	. Place of Di	sposition	(Name of	o or	nage	Date	20c. Location	- City or To	wn, Stat	te
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Baltimore, Maryland 21215-0020	permit. Page Department of important: if any injury or once.		4 Donation 5 Other				000 110									
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_	70 = e o		/ )leuch	21	The last	ni.						Hagerst		ırylar	nd 2	1742
			23a. Part1. Enter the disease shock, or heart failure. L	or comp	lications that	caused the de	ath. Do not	enter the	mode of dyi	ing, such as	cardiac o	or respiratory arr	est,		Approx	imate I Between
	Physician			,										ĺ	Onset a	and Death
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	Examiner		resulting in death)		a		(or as a con	-		ace	700			1		
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	uted d ansi	Ĕ	Sequentially list conditions		b. ———	Due to	(or as a con	sequence	of):							
<u> </u>	exectin an an riei-tr	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				`									
<b>6876</b> 0	eath certificate be executed attending physician and I for use as the buriel-transit	Physiclan/Medical Examiner	that initiated events	<b>S</b>	C	Due to	(or as a con-	sequence	of):							
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oj	the d y the	ys	Part II. Other significent cond	nions co	ntributing to d	eath but not n	esulling in th	e undeny	rig cause gr	veninran	١.					4 Unknown
Ţ.	The law requires that the death ate has been signed by the atte page 2 should be detached for											1 1 1	es 2 No	3 Proc	ably	4)CONKIIOWII
Š.	sign d be	g P										24a. Was a	n autonsv	24b. We	re autor	osy findings
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Vital Records,		Completed										1 □ Ye	s 2X No	1 🗆	Yes	2□ No
<u>e</u>	sician: The certificate irector, paç	Be	25. Was case referred to medi examiner?	-							of Death	(Check only on	e)			
	ysic is ce dire	2	1 ☐ Yes 2 No		Hospital: 1 🗆	Inpatient 2	☐ ER/Outpa	tient 3	DOA Ott	her: 4 Nu	rsing Hor	me 5 Reside	ence 6 □Oth	er (Specify	)	
0	Attending Physician: It death. sector: After this certific by the funeral director,		27. Manner of Death	all:a.a.	28a. Date	of Injury oth, Day Year)	28b. Time Injur		28c. Inju Wo	ry et	:	28d. Describe ho	w injury occur	red		
<u>ō</u>	nding F ath. r: After e funer	atie	1/X Natural 5 ☐ Pen 2 ☐ Accident inve	aing stigation		,,	,	М		Yes 2□	No					
UIVISION	Attendii r death. sctor: A by the fu	Ę	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	ld not be rmined	200. Flaci	of Injury - At	home, farm,	street, fac	ctory, office		. :	28f. Location (St City or Town		er or Rura	Route I	Vumber,
5	F = -	Certification:	4   Hornicide		Dulid	ing, etc. <i>(Spe</i>	city)					Oily or Town	, State)			
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	To the Hos within 24 h To the Fun completely	edical	(Check only 2 Medic one)	al Exem		asis of exemination of the state of the stat	nation and/or	investiga	tion, in my o	opinion, dea	th occurre	ed et the time, de	ate and place,	and due to	the cau	se(s)
	o the o	Me	29b. Signature and title of certi	fier					29c. Licens				9d. Date signe			
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•	10	-	20 Name and address of	on who o	ompleted seri	se of dash /"	am 22a) /T	ne Print)								
Ž	<b>├</b>		30. Name end address of person	A WIIO C	J_L	KLANIZA	2C 6	2014	100 -	trest	. 14	eigerste	run M	902	174	O.
1			31. Date filed (Month, Day, Ye	ar) _		Redistrar's Sig	nature	1	~ 3	- / (		0			-	
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			1 - For State Registrar	State of Marylan	d / Departm <i>Certific</i>	nent of Heal	Ith and Nath	Mental Hygien	°2004	05083
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last)     Aa. Fecility Name (If not institution, give:	Mildred Kay P	rice	City, Town, or Loca		2. Date of Death Month D February	ay Year	3. Time of Death  3:40 PM
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Funeral Director		400-32-6//3		ast birthday) If L	Inder 1 Year If U	Inder 24 Hrs.	8. Date of Birth (Month, Day, Yea, September 10.	Montgo 9. Bir 1922	omery thplecs (State or Foreign ountry) Tennessee
and 21215-0036	2 should be tiled within 72 hours after death with the Maryland and Mental Hydene. Is marked other then "natural", or items 23s or 28e-1 show aumatic event, the Medical Examiliser must be notified at	Be Completed by Funeral Director	Usuel Residence of Decedent  10a. State 10b. County  Maryland Montgo  10e. Street and Number  440 Bost	wick Lane  12. Was Decedent Ever in U.: Armed Forces? 1   Yes   2 No   If Yes, Give Year or Dates:	S. 13. Was E If Yes, 1 T Y	Gaith  f. Zip Code  2 Decedent of Hispan specify Cuban, Me es 2 No Spo  Usual Occupation of work done during DT use retired)  Homemake	ecity: n most of work	10g. C lecify Yes or No-Rican, etc.)	Unite  Unite  14. Race - Ame Black, Whit  Specify:  Vind of Business.  Own	10d. Inside City Limits 1  Yes 2  No puntry?  d States can Indian, e, etc.  Thite
Baltimore, Maryland	permit. Peges 1 and 2 should be I Department of Health and Menta I Important: if item 27 is marked or any injury or other traumatic eve	To	Norm  19a. Informant's Name/Relationship (Ty)  John Lee Pr  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funerat Service License	ice/ Son  emoval from State  Arri Nat	440 I ace of Disposition emetery, crematory Lington Lional Ce	Bostwick (Name of or other place) metery	Lane G Febi 12,	cuary Ar1	or Town, State, 2 Maryl ocation - City or	Zip Code) and 20878
1,60,	death certificate be executed  Particular of a strength of the	Icai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on timmediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Final Inc. Inc. Inc. Inc. Inc. Inc. Inc. Inc.	eations that caused the death	ac Arrest ence of): c Shock ence of): Failure ence of):	mode of dying, suc	th as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
O. Box 68	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetat 4 Pregnant at time of de	death 3 Ectop	ic pregnancy r (specify)			23d. Date of deli Month	very Day Year
cords, P.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions con	tributing to death but not resu	Iting in the underlyi	ng cause given in F	Part I.			the cause of death?
Ital Rec	The lar ate has page 2	e Completed	25. Was case referred to medical					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
on or v	ding Phys	Certification: To B	evaminer?		ER/Outpatient 3 28b. Time of Injury M	DOA Other: 4 [ 28c. Injury at Work? 1 □ Yes	□ Nursing Ho	me 5 ☐ Residence 28d. Describe how inju 28f. Location (Street ar City or Town, State	ry occurred and Number or Ru	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely tilled in by the	edical	one)	ician: To the best of my know er: On the basis of examination and manner stated.	viedge, death occur on and/or investiga	ition, in my opinion,	death occurr	ed at the time, date and	d place, and due	to the cause(s)
	T with To	×	29b. Signature and title of certifier  Attan Kasid  30. Name and address of person who cor	MD Ph	23a) (Type Print)	29c. License numb			te signed (Month	3, 2004
11	Sta Registr		Attan Kasid, M.D.  31. Date filed (Month, Day, Year)  FFR 0.6 200/		Road Roc	kville, N	Marylan	nd 20855		

State of Maryland / Department of Health and Mental Hygiene 2004 05084 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 36, 2004 11:08 A<sub>M</sub> **Physician** Florence Elaine Price /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring Holy Cross Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 30, 1 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1 ☐ M 2 🛱 F 579-18-1088 85 1918 Washington, Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c, City, Town or Location 10a. State 10b. County "natural", or itema 23a or 28a-f show Hygiene. other than "natural", or itema 23a or 28a-f shovent, the Mudical Examinar must be notified at M☐Yes 2☐No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 10820 Georgia Ave. #103 20902 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ ¥6s 2 ☐ No 1943— If ¥6s, Give Year or Dates: 1945 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black δ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Federal Government permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other than any injury outher traumatic event, the QRCS. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John E. Harris Florence Louise Peyton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent W. Price (son) 18416 Cherry Laurel Lane, Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 2/6/04 Suitland, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityMcGuire Funeral Service 21. Signature of Funeral Service Licenses homa 7400 Ceorgia Ave. N.W., Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction /Medical Due to (or as a consequence of) **Examiner** Pulmonary Embolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sick Sinus Syndrome Due to (or as a consequence of): P.O. Box 68760, attending physician Chronic Obstructive Pulmonary Disease Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 X Probably 4 □Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? Pneumonia certificate has director, page 2 autopsy performed? Yes 20 No 1 ☐ Yes 2 ☐ No 1 Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 🗓 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. ş 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0051670 January 30, 2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towana L. Spriggs, M.D. 1400 Spring Street, Suite 200 Silver Spring, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State oaks Registrar FEB 04

State of Maryland / Department of Health and Mental Hygiene 2004 05085 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 12:10 A M 30, 2004 Stephen Patten Potter January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1X M 2□F Sept. 13, 1922 Connecticut Director 002-16-8696 81 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ij Hygiene. • other than "natural", or Itams 23a or 28a-f show event. Ita Medical Examiner must be mulffed at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6606 Boxford Way 20817 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No WWII If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 X Marned altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Senior Vice President Petroleum Institute 5+ other traumatic event. 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Arthur Niles Potter Portia Patten 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health aitem 27 lb At of He. Ruth Headlee Potter/Wife 6606 Boxford Way, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Date 20c. Location - City or Town, State 20a Method of Disposition January 31, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Bethesda, Maryland 2004 Crematorium, 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue M01346Bethesda, Maryland 20814 Inc. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition OBSTRUCTIVE PULMONARY DISEASE YEARS **Physician** CHRONIC resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai as the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 5 Other (specify) ☐Yes 2☐No detached o 9 Unknown 9 Unknown يَ should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 Yes 3 ☐ Probably 4 ☐Unknown 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 1□ Yes 2 No Vitál Physician: in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To o 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death After 5 Pending investigation Injury Division 1 Matural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a
To the Funerel C perli 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JANUARY 30 2004 Lainer D36552 1511 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) fockville mp 20852 #401 Drive 50 W Edmonston Televar 32. Registrar's Signature 31. Date filed (Month, Day, Year) State oaks FEB 02 2004 Segrena Registrar

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N	PORTIL	LO.	1 = For State Registrar Unpend Item	State of M	laryland	/ Depa	artment of H	ealth ar Death	nd Mental	Hygier		104	05086
			Decedent's Name (First, Middle, L.	<b>[23a,21,26a-1</b> ast)	rer ME,	GOZY:	O/1Z/U4CZ		2. Date of	f Death		V	3. Time of Death
	Physici		Juan M. Porti	11o					JAN		Day 200	Year )4	0128 A M
	/Medic Examir		4a. Fecility Name (If not institution, g	ive street and number	r)		4b. City, Town, or	Location of I	Death		4c. County	of Death	
			NEW HAMPSHIRE AV				Takoma				MONTO		
	Funeral			Sex 7. A 1XIM 2□ F	ige (In yrs. lasi	t birthday) Yrs.	If Under 1 Year Months Days		Min. (Montl	n, Day, Yea			nlace (Stete or Foreign ntry)
	Director		592-33-3211 Usuel Residence of Decedent		19	115.			Apr.	18, 1	.984	Hond	uras
	land		10a. State 10b. County		10c. City, T	Town or Lo	cation					1	0d. Inside City Limits
	Mary -1 sh	to	Maryland Princ	e George's		Adel	nhi						1 ☐ Yes 2 ☑ No
	r 28s	rec	10e. Street and Number	e ocorge s	<u> </u>	nucı	10f. Zip Code			10g.	Citizen of V	What Cour	ntry?
	h with	a D	1713 Merrimac Dr	ive			20783	3			US	SA	
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show ta Modical Exercites transites recitified at	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces		13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origir In, Mexican, I	n? (Specify Yes of Puerto Rican, etc	r No- .)		e - Americ k, White,	ean Indian, etc.
9	or It	by Fu	1 ☑ Never Married 2 ☐ Married	If Yes, Give	_		1⊠ Yes 2□ No	Specify: H	onduran		Specify	· Wh	nite
Š	urel,	D D	3 Widowed 4 Divorced	Year or Dates			dent's Usual Occupa			16h	. Kind of Bu	isiness/Inc	dustry
ç	n 72 n "nai	Completed	(Specify only highest g	rade completed)		(Give	kind of work done of DO NOT use retired	during most o	f working				
21212-0036	withi iene. ther	E	Elementary/Secondary (0-12)	College (1-4or		Warel	nouse Wor	ker		Ai	r Con	ditio	oning
0	Hyg other	Be C	17. Father's Name (First, Middle, Las	st)					s Name (First, Mi				
lan	ald be fenta rked tic sv	To B	Milton Por	tillo				C	armen Pi	neda			
and	and N		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street a	and Number	or Rural Route N	umber, Cit	y or Town,	Stete, Zip	Code)
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itsm 27 is marked other then "naturel", or items 23s or 28s-f show may njury or other traumetic svent. If a Maxical Examiner must be notified at 2008. (\$\sigma\$^-\sigma\$).		Carmen Pineda/	Mother			West 35t	h Stre					
	of Ho		20a. Method of Disposition 1 ⊠ Bunal 2 ☐ Cremation 3	☐Removal from Stat	com	e of Dispo	sition (Name of matory or other plac	e) Fe	Dete bruary 4		Location -	City or To	own, State
Ē	Pagint Inner		* 4 □Donation 5 □ Other (Spec	cify)			orial Gard	lens	2004		ami L	ake,	FL.
ğ	Departition of the popular in portion of the popular in		21. Signature of Funeral Service Lic	90500		F	2. Name and Addres	collity Collin	ns Fune	cal H	ome I	nc.	
	40300		23a. Part 1 Enter the disease, or co	molications that cause	a thadaath	Do not ent	00 Univer	sity B	Ivd. W.	Sil	ver S	pring	Approximate Interval Between
8760,	Physician /Medical Examiner hysician and phiasician and phiasician and the phiasician and	I Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	E Injurie  s a consequer  s a consequer  s a consequer	nce of):							
P.O. Box 687	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	4□Pregnant 9□Unknown	2 Fetal de at time of deat	eath 3[	Ectopic pregnancy Other (specify)		230.	Did tobacc	Мо		Day Year
ecoras,	law requires that the as been signed by th 2 should be detache	ted by								1 🗌 Yes	2□No	3 🗌 Prob	ably 4 Unknown
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VItal	Physician: The this certificate ral director, pages	Be	25. Was case referred to medical examiner?	Hospital:			- 2CL DOA Oth		f Death (Check o		v	/	AT SCENE
0	Physic rthis c ral dir	2	27. Manner of Death	1 Inpa	i 20	VOutpatier 8b. Time o	IL 3 DOA		ing Home 5		6 Oth		y) AT SCHILL
Division	or Attending utter death. Director: After	Certification:	1 Natural 5 Pending investigat 3 Suicide 6 Could not determine	found 1/31	I/O4 Injury - At hometic. (Specify)	und 1:20	Worl	k? Yes 2∰ No	Subject 28f. Locati New Har	t driv	ver of	vehic vehic	le involved i ular collision A Route Number, rwood Drive
	Hospitel 4 hours a Funeral i	62	(Check only 2 Medical Ex	Physicien: To the besaminer: On the basis and manner	st of my knowle	edge, deat n and/or in	h occurred at the time time to the time of time of the time of time of the time of tim	ne, date and pinion, death	place, and due to occurred at the t	the cause	(s) and ma	inner as st and due to	tated. o the cause(s)
	thin 2 the mplel	Medic	one) 29b. Signature and title of certifier	and manner	3,4,60.		29c. License	e number		29d.	Date signed	d (Month,	Dey, Year)
	To To		17.1	11 11 .	Y	1	0.0	.M.E			JAN.		2004
			30. Name and address of person wh	Completed cares	death (Item ?	3a) (Tuna							
				ras			n Street,	Balt:	imore. M	arvla	nd 21	201	
	St	ate	31. Date filed (Month, Day, Year)		strar's Signatur								
	Regist		FEB 0 2 2	nna Den	wa	19	Sparks						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 05087 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Day Month **Physician** February 1, Dixie Logan Porter 2004 4:15P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Yrs. 1928 Kentucky 070-22-2633 June 25. Director 75 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23e or 28e-f show 1 ☐ Yes 2 📆 No Directo Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 2809 Blazer Court 20906 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. d other than "natural", or Items event, the Madical Examiner m 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: þ 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Office Furniture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: It lem 27 is marked oth any injury or other treumatic event once. James Ralph Davis Lillian Marigold Logan 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2809 Blazer Court, Silver Spring, Maryland 20906 Richard Logan Porter/Son 20b. Place of Disposition (Name of commetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State rematory or other place)
ery
rium, Inc.
8,2004

Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805

Approximate 1 ☐ Burial 2 XCremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) 21. Signatural Service Intensee M00803 Rockville, Maryland 23a. Pert1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine physician at s the burial-t Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ģ cate has been signated bage 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate } 1 ☐ Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Phenatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Jan, MD 00057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13219 Executive Park Terrace, Germantown, Maryland Truong Bao, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 06 2004 Registrar

DHMH 17 Rev 1/2001

PORTER, DIXIE

State of Maryland / Department of Health and Mental Hygiene 2004 05088 For State Registra Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 3, 2004 **Physician** PLOINICK ROSE 5:50A. M /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hebrew Home of Greater Washington Montgomery Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Statements) | April 18,1908 | Maryland 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funeral 1□M 2₩F 95 Director 577-34-8373 Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other then "naturel", or Itema 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State id other then "naturel", or itema 23s or 28s-f show event, the Micalcal Experience, stat Le notified at 1 Yes 2 □ No Maryland Montgomery Rockville Director 10e. Street and Number 6121 Montrose Road, #566N. 10g. Citizen of What Country? 10f. Zip Code 20852 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Stetus 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Accountant private 12 1 - 418. Mother's Name (First, Middle, Maiden Sumame) permit. Fages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Plotnick Ethel Nathan Babynoure 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14907 Forest Landing Circle Rockville, Maryland20850 Stuart Plotnick -nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 2/5/2004 Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. and Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atheroiclerate disense /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the pest 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 → Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 NO 1 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? After 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number D55253 tebruary 5 m. D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilks, MID. 6121 MONTROJE RUADROCKUILLE MAKYLAND 20052 13-31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 05

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 05089 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day February 3, **Physician** 2004 10:45 P M Eloise Wilson Phipps /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert 3570 Windsor Lane Huntingtown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 ☐ M 2 🖾 F Yrs 91 May 26, 1912 Director 577-03-6664 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinating the multiple at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No Director Huntingtown Maryland Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20639 3570 Windsor Lane USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: White þ 3 ⊠Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nelle Louise Flegal George Washington Wilson, III 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3570 Windsor Lane, Huntingtown, MD 20639 Margaret Evans/ Daughter Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 8 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 □Donation 5 □ Other (Specify) Parklawn Memorial Park 2004 Rockville, Maryland 22. Name and Address of Eachlity
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee I.llio 500 University Blvd. W., Silver Spring, MD 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Obitructi hronic resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2□ No this certificate 1 Yes 1 Yes 2 3 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: Hospital: 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 은 1 Yes 2 No 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 15 C 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) solomons Is Rd WD 50630 MATHEW W. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 06 FEB Registrar 2004

DHMH 17 Rev 1/2001

			For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artment of Hertificate of L	ealth and Death	d Mental Hy	giene Reg. No.	2004	05090
			1. Decedent's Name (First, Middle	, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia	_	Paul Marlin	n Phillir	s				Januar			8:09 ам
	/Medic		4a. Facility Name (If not institution				4b. City, Town, or	Location of De	eath	4c. C	County of Deat	h
	LXdiiiii	٠.	Holy Cross	Hospital			Silver	Spring	2	М	lontgom	erv
	Funeral		5. Social Security Number	6. Sex		. last birthday)	If Under 1 Year Months Days	If Under 24 F		th Year)	9. Birt	hplace (State or Foreign
	Director		219-58-6151	1⊠M 2□F	48	Yrs.	Months Days	Hours W	Sept.	ĺ1, ĺ19	55 Mar	yland
<u> </u>			Usual Residence of Decedent		1 40 0							40d lasida Oita Lissia
nylar	tel.	_	10a. State 10b. County			city, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☒ No
e Ma		ct	Maryland Montg	omery	K	ensingt						
타	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Co	ountry?
death with the Maryland	23s		10800 Pearso	n Street			20895				USA	
r dea	E 9	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in I Forces?	U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? n, Mexican, Pu	? (Specify Yes or No Jerto Rican, etc.)	)- 1·	<ol> <li>Race - Ame Black, White</li> </ol>	
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Maryland d 2 should be fife	od Mental Hyglene. marked othar than "natural", or Itams 23e or 28a-f show imatic avant, it e Medical Examinar must be notified at	၉	19a. Informant's Name/Relationsl	-	трь	19h Mailir	ng Address (Street a			er. City or	Town, State, 2	Zip Code)
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<b>a</b>	Heall am 2 thar		20a. Method of Disposition	The A		A Secretary Company of the Company o	sition (Name of matory or other place		Date		ation - City or	
င္က် နွိ	48 = 30		1 ☐ Burial 2 ☑ Cremation		n State	-	-	104.	nuary 30	4.1		***
Baltimore, Dermit. Pages 1 ar	rtmer rtant rjury		* 4 ☐ Donation 5 ☐ Other (S <sub>i</sub> 21. Signature of Funeral Service		Me	tropoli	tan Crema	tory				Virginia
	Department of Health and Men Important: If itam 27 Ia marke any injury or other traumatic once.		Anama of Funeral Service	Merrer	ker	50 50	rancis J. O Univers	Collin	ns Funera vd. W., S	l Hom ilver	ne Inc. Sprin	g,MD 20901
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	t caused the dea	ath. Do not ent	er the mode of dying	g, such as care	diac or respiratory a	rrest,		Approximate Interval Between
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	Medical		resulting in death)	a. Due t	o (or as a conse		Caraje	/ NON	41011 0.1	Octo		
Ex	aminer			b. ———								
	_	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		o (or as a conse	quance of).						
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Records, P.O. Box 68760, The law requires that the death certificate be executed	physician and the burial-transit		resulting in death) Last	Due to	o (or as a conse	equence of):						
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<b>68</b>	ng ph as th	Jed	IE EEMALG.	T								
Box eath cer	ed by the attending p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of preg		Ectopic pregnancy			23	3d. Date of del Month	ivery Day Year
dea dea	ed to	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pre- 9 □ Unk	gnant at time of	death 5	Other (specify)				MOITH	Day
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Records,	been si should l								_ 10	Yes 2□	]No 3  X(₱r	obably 4 Unknown
a ĕ ĕ	S CA	Completed							_ 24a. Was		24b. Were au	utopsy findings available completion of cause of
<u> </u>	page 2	ē							perfe 1 ☐ Yes	ormed? 2 ⊠ No	death?	\/
Vital sician: 1	certificate rector, pag	0	25. Was case referred to medical					26. Place of	Death (Check only	- / -		
	. <u>∞</u> =	To B	examiner? 1 X Yes 2 ☐ No	Hospital: 1	☐Inpatient 2	ER/Outpatier	nt 3 DOA	er: 4 🗆 Nursin	ng Home 5 ☐ Res	idence 6	Other (Spe	cify)
vision of Vital	n. After th funeral	Ę.	27. Manner of Death	/ 1 40	te of Injury onth, Day Year)	28b. Time o Injury	f 28c. Injury Work	at	28d. Describe	how injury	occurred	
	death. ctor: Af y the fur	atic	1 Natural 5 Pendin 2 Accident investi	gation			M 101	Yes 2 □ No				
Division of or Attanding Physical	racto	Certification:	3 ☐ Suicide 6 ☐ Could determ	ined 200. Fid	ce of Injury - At Iding, etc. (Spec	home, farm, str	reet, factory, office		28f. Location ( City or To	Street and wn, State)	l Number or Ru	ural Route Number,
ig O	rs aft al Di led in	Çe							1			
Div To the Hospital or	within 24 hours after death.  To the Funaral Diractor: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifyir (Check only 2 Medical one)	Exeminer: On the	the best of my ki basis of examinations	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my op	ne, date and ploinion, death o	lace, and due to the occurred at the time,	date and p	and manner as place, and due	s stated. to the cause(s)
o the	within 2  To the complet	Me	29b. Signature and title of certifie	r	0 11	n 6.	29c. License	number		29d. Date	signed (Mont	h, Day, Year)
			> Patricia	10ms	Re 1	lay, M	D D	5191	6'	Va	n, 28	8, 2004
8	6		30 Name and address of person	who completed ca	use of death (It	em 23a) (Type,	Print) N	aid r	2 4 1	6 1	111)	0050
سندو			Patricia loms	Ko IVay	Registrar's Sig	IIIONT	rase Ko	au, K	0C/V//	K, 11	IV d	0852
H	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 2		Hegistrar's Sig	B	sparks					

Physic	ian	1 - State Registrar  1. Decedent's Name (First, Mic ELEANOR PAV	Idle, Las				Certifica	le or	Deali	-	lental Hy  2. Date of Do  Month  Januar	aath	, 20		0509 3. Time of Deat 10:50	th
/Med Exami		4a. Facility Name (If not institut		street and nur	nber)		4b. City	, Town, o	r Location	of Death				of Death		
		Casey House						ckvi]		or 24 Hrs.				gomer		
Funera Director		5. Social Security Number 136-34-6537	6. S	9X □M 2 <b>X</b> F	-	yrs. last birth	Months	Days	Hours		8. Date of Bi (Month, D Jan . 1	2,19	12	9. Birthi Cour New	place (State or For ntry) York	ыgп
D		Usual Residence of Decedent 10a. State 10b. Cour	the state of the s		100	c. City, Town	or Location							1	10d. Inside City Lin	nits
Maryla f shov	jo			unde1	1		a Park								1 □ Yes 2 📉	
death with the Maryland ms 23a or 28a-f show Iriust be notified at	Funeral Director	10e. Street and Number					10f. Z	ip Code				-		What Cou	•	
sath wi	eral	315 Dunham Co	urt	12. Was Dece	dent Ever	in IIS	13 Was Dec		L146	rigin? (Sp	acify Yas or N			Stat	es can Indian,	
036 urs after de ur, or item	by Fune	11. Marital Status  1 Never Married 2 M  3 🖾 Widowed 4 Divorce		Armed Fo 1 [] Yes If Yes, Giv Year or D	rces? 2 <b>X</b> No ∕e	11 0.3.	If Yes, sp				ecity Yes or N Rican, etc.)			ck, White,	etc.	
21215-00 21215-00 ed within 72 hou ygiene.	eted	15. Deced (Specify only high	ent's Ed hest gra	lucation de completed)	-	16a. l	Decedent's Us 'Give kind of w life. DO NOT	ual Occup	ation during mo	st of work	ing	16b. K	ind of B	usiness/In	idustry	
within within than	Completed	Elementary/Secondary (0-12	}	College (1	-4or 5+)		istere;					Не	alth	ı Car	e	
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner man by indifficial	To Be C	17. Father's Name (First, Midd Worthen Gille									e (First, Middle ancaste		Suman	пө)		
Mary Mary 12 shot		19a. Informant's Name/Relation Robert Pavlak									a <i>l R</i> oute <i>Numb</i> ithersb					
AU IAK  Ore, Mar  or 1 and 2 shu tot Health and If item 27 is m		20a. Method of Disposition			20		Disposition (No., crematory or			Market	Date	-			own, State	
Page Way or Holy or H	2	1 ☐ Burial 2 🎇 Cremation 1 ☐ Donation 5 ☐ Other			State		olitan	Crem		Feb. 200	04,	Ale	xand	lria,	Va.	
Balt Balt Dermit. Depart Imports Imports any injure.		21. Signature of Funeral Servi	0	Des			1	st De	er P	ark l		ther			d. 20877	
Say Secure to the executed Physician and physician and physician and the burial-transit	cai Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ast only	a. Mult Due to  Due to	i Inf		ementi								Approximate interval Between Onset and Death Years	
vision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certificate r death. sctor: After this certificate has been signed by the attending phys by the tuneral director, page 2 should be detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes 2 ☑ No 9 □ Unknown			oirth 2 🗌 nant at time	Fetal death	3 □Ectopic 5 □ Other (		y					te of deliventh	ery Day Year	
ds, P juires that n signed b	d by Pl	Part II. Other significant cond	litions o	ontributing to d	eath but no	ot resulting in	the underlying	cause giv	en in Parl	t I.		tobacco i			he cause of death bably 4 DUnkno	
Division of Vital Records, P.O. Ior Attending Physician: The law requires that the datter death.  Director: After this certificate has been signed by the time tuneral director, page 2 should be detached	Complete										24a. Wa: auto peri 1 🗆 Yes	opsy omed?	!	Were auto prior to co death? 1  Yes	opsy findings avails empletion of cause 2 No	able of
Vital Fidelan: The certificate	Be	25. Was case referred to med examiner?	ical	Hospital:	101			Ott			h (Check only				150.	
Of Physic	To To	1 ☐ Yes 2 🔯 No 27. Manner of Death		28a. Date (Mon		2 ER/Out	me of	28c. Injui	ry at	Nursing Ho	ome 5 Res 28d. Describe				WHospice	
Vision o Attending PI r death. ector: Alter th	atlor	2 Li Accident	stigation	n	th, Day Ye	ar) in	jury M	Woi 1 □	rk? Yes 2[	]No						
Divis al or Atte s after de al Directo	Certification:	3 Suicide 6 Cou	ild not b ermined		of Injury - ing, etc. (S	At home, fan Specify)	m, street, facto	ory, office			28f. Location City or To	(Street and own, State	nd Numb )	er or Rura	al Route Number,	
Division of Vital Recont to the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the tuneral director, page 2	Medical (			nysician: To the niner: On the b and man		mination and										
To the within To the comp	M	29b. Signature and title of cert	ifier	/ -			2		e number 2452	r					Day, Year)	
10		30. Name and address of pers	on whe	completed caus	se of death	(Item 23a)	Type, Print)	<u>гш4</u>				гес	ı ua	ту 1,	, 2004	
		Dr. Chitra Ra						nilli	p Dr	. 01n	ey, Md	. 208	332			
	tate	31. Date filed (Month, Day, Ye FEB 0 4	-		legistrar's	Signature	Sp	als								

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar	nd / Depa <i>Cer</i>	rtment of Hea	ith and M ath	lental Hygie	ene 3. No. 200	4 05092
	-		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Ye	3. Time of Death
	Physicia /Medic		ROBERT ELT	ON PARE	RISH			January	30 200	04 1:55 A M
	Examin		4a. Fecility Name (If not institution, give 6001 Muncaster Mil	street and number) 1 Road, Casey	/ House	4b. City, Town, or Loc Rockv			4c. County of D Monto	eath Jomery
+ , -	Funeral Director		5. Social Security Number 6. Security 257 26 9244	7. Age (In yrs. 7) 7 7 7 7 7 7 6			Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, ) Mar. 21	rear)	Birthplace (State or Foreign Country) Georgia
	D .		Usuat Residence of Decedent  10a, State 10b, County	10c. C	ty, Town or Lo	cation				10d. Inside City Limits
	faryla hov	5	Md. Montgom		•	r Spring				1 ☐ Yes 2 🛣 No
	28a-1	ect	10e. Street and Number	Ci J		10f. Zip Code		100	g. Citizen of What	Country?
	3a or	Funeral Director	13130 Valleywood	Drive		20906			United S	States
	ms 2	Jera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. \	Vas Decedent of Hispai Yes, specify Cuban, M	nic Origin? (Spe	ecify Yes or No-		merican Indian, /hite, etc.
9	after or Ite	Fu	1 Never Married 2 Married	1 XYes 2 No			pecify:	riloari, otc.)	Specify:	White
9	rel'.	d by	3 Widowed 4 Divorced	Year or Dates: WW.	1 1			1		
2	"natu	lete	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	lent's Usual Occupation kind of work done durin OO NOT use retired)	n ig most of worki	ing 16	8b. Kind of Busine	ess/Industry
21215-003	withir ene. then	Completed	Elementary/Secondary (0-12)	Cottege (1-4or 5+)		sman			Hard	ware
0	Hygi other	Be C	17. Father's Name (First, Middle, Last)		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Mother's Name	(First, Middle, Ma	aiden Sumame)	
<u>a</u>	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "naturel; or Items 23a or 28a-f ehow atto event, the Medical Examinar must be notified at	To B	William Wesley	Parrish			Laura	Ranson		
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene and Mental Hygiene is marked other than "naturel, or litems 23a or 28a-f show aumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Street and ) Valleywood	Number or Rura	Route Number, (	City or Town, Stat	e, <i>Zip Cod</i> e) Md. 20906
≥,	and lealth m 27 her tr		Margaret M. Parri			sition (Name of			oc. Location - City	
Ore	ges 1 If of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	Removal from State	cemetery, cren	natory or other place)	l l			
altimore,	it. Pa		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>	****		tan Crem.		1/04	Alexand	ria, va.
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury, or other traumatic events.		Murul &	Bach		Name and Address of Muriel H.	Barber	Funeral I Laytonsv	Home	20882
			23a. Part1. Enter the disease, or compl	ications that caused the dea	th. Do not ent					Approximate Interval Between
	Physician		shock, or heart failure. List only of immediate Cause (Final		אחא פ	MALL CELL	LUNG CA	NCFR		Onset and Death 6 Months
	/Medical		disease or condition resulting in death)	Due to (or as a consec		MALL OLLL	Lona on	HOLIK		
	Examiner		Sequentially list conditions	b						
	<u>ч</u>	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):					
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	guence of):					
760,	death certificate be executed e attending physicien and id for use as the burial-transit	calE		_	111					
687	fficate g phys			1.						
Box	death certifica attending pl d for use as t	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 Live birth 2 Fet		Ectopic pregnancy			23d. Date of	
m .		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of e		Other (specify)			Month	Day Year
o.	that the de led by the a detached f	Phys	9 Unknown				D	02a Didasha		e to the cause of death?
Ś	8 20	by	Part II. Dther significant conditions co	ntnbuting to death but not re-	suiting in the ui	nderiying cause given in	ranı.			Probably 4 Unknown
0.0	w require been si should t	eted								
Records,	has t	Completed						24a. Was an autopsy performe	prior death	
			25. Was case referred to medical			26	Place of Dooth	1 Yes 2		′es 2□ No
<b>=</b>		To Be	evaminer?	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatien	0.1		me 5 ☐ Residen		Specify) Hospice
ō	ding Phys th. : After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c, Injury at Work?		28d. Describe how		7 11035100
0	Attanding ir death. ector: After by the funer	atlo	1. ☐ Natural 5 ☐ Pending investigation	(1101111)	,.,		2 🗆 No			
Division of Vital	or Attandated attended attended to Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str fy)	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	oitel o	Ce	1000 - 11 - 10 - 10 - 10 - 10 - 10 - 10	alaian Tabahahan dan ka	audadaa daat		fate and place	and due to the cou		· oa stated
	To the Hospitel or Attanwithin 24 hours after deati To the Funerel Director: completely filled in by the	edical		sician: To the best of my kn iner: On the basis of examinand manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	110		29c. License nu	mber	290	d. Date signed (Me	onth, Day, Year)
9-	11		Willoss,	ter	~ m	DOD C	4121	8 1	1/30/0	04
1)	5~ 1		30. Name and address of person who ca		m 23a) (Type,	Print)	DOAD 5	OCKVIII	MD 2	0855
			CHARLES HARRISON			ASTER MILL	KUAD, F	COUNTILLE	, יטויי ב	.0033
	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 2 201	32. Registrar's Sign	ature &	Sparker				

			1 - For State Registrar	State of Maryl		partment of I			giene 200	4 05093
,	Physici		1. Decedent's Name (First, Middle, La	st)		PAN	JAGOS	2. Date of Dea Month Janua	Day Yee	3. Time of Death 4 233 PM
	/Medic Examir		4a. Fecility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of Death		4c. County of De	ath
	CAGIIII	iei	The Johns to	Pkins Host	14/	Palst	more C	1+1	Baltim	ore
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthda		If Under 24 Hrs.	8. Date of Birth	h 9. B	irthplace (State or Foreign Country)
	Director		577-16-4979	IXIM 2□F	82 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day July 15	, 1921 Wa	shington, DC
	p ,		Usuel Residence of Decedent	100	. City, Town or	l aaatia a				10d. Inside City Limits
	aryla	ڀ	10a. State 10b. County		. City, Town or	_				1 ☐ Yes 2√ No
	88-1	ecto	Maryland Montg	omery		Potomac			10g. Citizen of What (	
	within 72 hours after death with the Maryland sne. then "natural", or items 23a or 28a-f show ha Madisal Examena must be notified at	Completed by Funeral Directo	10e. Street and Number	D		10f. Zip Code	00051		U.S.A.	Southly?
	s 23	eral	9944 Potomac Man	12. Was Decedent Ever	in U.S. 13	Was Decedent of	20854 Hispanic Origin? (S	pecify Yes or No-		nerican Indian,
	item de	un.	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?	lor1d		Hispanic Origin? (S ban, Mexican, Puert	o Rican, etc.)	Black, Wi	
36	irs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: Wan		1 ☐ Yes 2 🔀 No	Specify:		Specify: W	nite
5-0036	2 hou	ted	15. Decedent's E		16a. Dec	edent's Usual Occu	pation	4.1	16b. Kind of Busines	s/Industry
215	nin 7	ple	(Specify only highest grade) Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retire	e during most of wor ed)	King		
2121	filed with Hygiene. Ither the	0.0		4	0w	ner/ Edit	or		Gaithersb	urg Gazette
	be filed ttal Hygid d other	Be (	17. Father's Name (First, Middle, Last						Maiden Sumame)	
Vlai	ould be Mental arked o	70	Milton Panag	os			Evdoki	a Kouis		
Maryland	and and		19a. Informant's Name/Relationship (	- T		-			r, City or Town, State	
	1 and 2 Health Iom 27 i		Mary Ann Panago				Manors D	17		20854
ore	of H of H if ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 E			position (Name of rematory or other pla		Date	20c. Location - City of	
Ë	Paris Paris		'4 ☐ Donation 5 ☐ Other (Speci	<sub>fy)</sub> G		Heaven Ce		3, 2004		Spring, MD
Baltimore,	permit. Peges 1 and Department of Health Important: If item 27 eny injurger other tr		21. Signature of Funeral Service Lice	"   / / / -		22. Name and Addr	ress of Facility Jo	seph Gaw	ler's Sons	, Inc.
ш	40 E 9 9		1/1/20mg C	/ ~					ashington,	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	pplications that caused the cone cause on each line.	death. Do not e	nter the mode of dy	ring, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician	l l	Immediate Cause (Final disease or condition	. ACUTE	MYEI	-06ENO	US LE	UNEW	NA	5 monThs
	/Medical Examiner		resulting in death)	Due to (or as a con						
18.	LAdminer		Sequentially list conditions,	b. NEUTR Due to (or as a cor		IL SEP	SIS			2 DAYS
	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			2	\			SHOURS
	ecut and I-tran	хап	that initiated events resulting in death) Last	c. ATTUAL  Due to (or as a con		RILLATIO	010			21100102
760,	be execu icien and burial-tra	calE		`		CEPIN AT	rory FA	41.1016		IDAM
687	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	_		d. 1111		C) ( 110/4 .	, 1 V /	11000		1
×	certifica Iding ph	Physiclan/Med	IF FEMALE:	23c. If yes, outcome of pre	egnancy				23d. Date of d	eliverv
Вох	death of atten	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		☐ Ectopic pregnand ☐ Other (specify)	cy		Month	Day Year
P.O.	the d y the	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
	The law requires that the tte has been signed by th bage 2 should be detache	by Pi	Part II. Other significant conditions	contributing to death but no	t resulting in the	underlying cause g	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	w requires to been signed should be	d b						1 🗆 Y	'es 2 No 3□	Probably 4 Unknown
Records,	w red	Completed						24a. Was	an 24b. Were	autopsy findings available
Re	he la e has age 2	E						autop perfor	rmed? death'	
Vital	(0		25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·		26. Place of Dea	1 ☐ Yes		15 22 110
>	Physician: this certific ral director,	To Be	examiner?	Hospitaf:	2 ER/Outpat	ent 3 DOA	thor		lence 6 □Other (Sp	ecify)
οt	g Physical this neral di		27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time		ury at	28d. Describe h	ow injury occurred	
io	Attending F r death. ector: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	on	,		Yes 2 □ No			
Division	er de recto by th	Tiffic	3 Suicide 6 Could not l		At home, farm,	street, factory, office	•	28f. Location (S City or Tow	Street and Number or a m, State)	Rural Route Number,
	tei or rs aft ei Di	Cer		, , , , , ,						
	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Medical Certification:		hysician: To the best of my miner: On the basis of example of the basis of the						
	the hin 24 the F	ed	one)	and manner stated.					444	
	To To	2	29b. Signature and title of certifier	> 11177	2 4 1		nse number		29d. Date signed (Mo	
	20		214 LAV	S INTE.			5-000	,	JANUAM	c7, 600 4
	1		30. Name and address of person who	A	(Item 23a) (Typ	e. Print)	TUSST	- AIT.		
	<u> </u>		SCOTT BERNOWTZ					BACIIVA	one, mar	1 LAND 21287
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 4 20	32. Registrar's S		Spark.	2/			

DHMH 17 Rev 1/2001

			For State Registrar		State of I	Marylar	nd / Depa <i>Cei</i>	artment of rtificate o	Heal f Dea	th and ath	d Menta	l Hygi	iene 20	04	05094
	Physici		1. Decedent's Name (First,		Palen						2. Date Mor	of Death		Year	3. Time of Death 10:22AM
	/Medio Examir		4a. Facility Name (If not inst		street and number	er)		4b. City, Town	, or Loca	tion of D			4c. County of	of Death	
					HOSPITAL				VER				MON	TGOM	
	Funeral		5. Social Security Number	6. Se	x 7. □M 2 <b>X</b> □F		last birthday) Yrs.	If Under 1 Year Months Day		nder 24 h urs N	lin. (Mo	of Birth oth, Day,	Year)		place (State or Foreign httry)
	Director		083-20-7083 Usual Residence of Decede			93					OCT	. 11,	, 1910		PA.
	/land		10a. State 10b. Co			10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Limits
	Many Fred	ţ	MD. MO	NTGOM	ERY			SILVER	SPR	ING					XXYes 2 □ No
	th the or 28,	ie	10e. Street and Number					10f. Zip Code				10	g. Citizen ol W	hat Cour	ntry?
	23e ust b	ai E	2316 BLU	E VAL	LEY DR.				2090					S.A.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumatic event, the Medical Examiner must be nuitilised at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □  3 XWidowed 4 □ Dive		12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	xNo		Was Decedent of Yes, specify Co			' (Specify Yes Jerto Rican, e	s or No- tc.)		c, White,	ean Indian, etc. ITE
0-10	72 hor	ted	15. Dec (Specify only I	edent's Ed			16a. Dece	dent's Usual Occ kind of work dor	upation	most of	working	1 1	16b. Kind of Bus	siness/In	dustry
215	within 7 ene. then "r	Completed	Elementary/Secondary (0		College (1-4	or 5+)	life.	DO NOT use reti	red)		WOINING				
	e filed wi Il Hygien other th	် ပ	12				<u> </u>	MERCHAN			V- (5)		RETA		
ınd	be fift d off	Be	17. Father's Name (First, Mi		a Dr. T	Mann			18. K	iotners i			Maiden Sumame		
3	2 should be and Mental is marked eumatic ev	ဥ	MOR 19a, Informant's Name/Rela	RIS		NGER	10h Mailir	ng Address (Stre	at and M	ımber or	JENI Bural Boute		City of Town S		Code
altimore, Maryland	nd 2 sl lith an 27 is r r treur	1	JOAN M. SC			,	Y.	BLUE VA							
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P.O. Box 68	ath certif ttending or use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	н	23c. if yes, outcor 1 ⊟Live birth 4 ⊟ Pregnant 9 ⊟ Unknowr	2 ∏ Feta t at time of d	uldeath 3□	Ectopic pregnar Other (specify)	су				23d. Date Mont		ery Day Year
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	~		30. Name and address of pe	rson who d	1		n 23a) (Type,				•	70	n71. D	r. ±	t430
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State of Maryland / Department of Health and Mental Hygiene 2004 05095 For State Registrer Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year AM **Physician** Tammy Lynn Peters January 27 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 ☐ F 44 Maryland Feb. Director 217-80-9225 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at 1√1 Yes 2 □ No Hagerstown Washington Direct 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number USA 21742 13700 Emily Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 ie marked other than "natural", or ite 1 ☐ Never Married 2√ Married White 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify If Yes Give þ 3 ☐ Widowed 4 ☐ Divorced ear or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accounts Receivable Royce Hosiery 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jo-Ann Kathleen Koontz John William Keller ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health at Important: If Item 27 ie any injury or other trau Joseph A. Peters/Husband 13700 Emily Street, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 15 Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 2/3/2004 Hagerstown, MD Rest Haven Cemetery 22. Name and Address of Facility Rest Haven Funeral Chapel Hagerstown, MD 21742/1601 Pennsylvania Avenue 21. Signature of Funeral Service vicense 23a. Part1. Enter the disease, or complications on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Year for Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Vas 2 No has page 2 certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: Hospital: 1 Inpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 257 No 2 ER/Outpatient this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death Certification: Aiter Hospital or Attending 5 Pending investigation atural 1 ☐ Yes 2 ☐ No death. М 2 Accident Director: in 24 hour. the Funeral Directory of filled in by the 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35 der 117 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 JAN 9 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Donald Wilbur February Pullin, Sr. 2004 5:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 515 E. Fourth Street Allegany Cumberland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 0 3 / 24 / 1 9 3 2 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2□F 71 Yrs Director 213-24-6565 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at ₩XYes 2 No Director Allegany Cumber land 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21 Beechwood Drive 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 XWidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within al Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Department Store permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 1s marked other any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha Leona Dilfer Wilbur Empson Pullin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald W. Pullin, Jr. / son 521 Hilltop Drive, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 02/06/2004 Cumberland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that asset the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancer of Gallbladder <u>11 months</u> /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner led by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 ANo this certificate has 1 🔲 Yes 2 🗆 No 1 ☐ Yes tat or Attending Physician: T satter death.
s atter death.
al Director: After this certificate of in by the funeral director, pa Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence ၉ 1 ☐ Yes 2 🗓 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitat o within 24 hours aft To the Funeral DI 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D17565 February 4, 2004 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 922 National Highway, LaVale, MD Anthony J. Bollino, Jr., M.D., 32. Registrar's Signature State Registrar

			1 - For State Ragistrar	State of Ma	ryland / De <i>C</i>	partment of F ertificate of	lealth and M Death	lental Hyg	iene 2004	05097
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medic		Marilyn Naomi	Rogers				January		12:05A M
	Examin	er	4a. Facility Name (If not institution, give s				r Location of Death		4c. County of Deat	
			13237 Lake Geneva 5. Social Security Number 6. Sex		(In yrs. last birthd		intown If Under 24 Hrs.	9 Date of Birth	Montgome	J
	Funeral Director			M 2⊠F	64 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 14	Year) Co	hplace (State or Foreign untry) th Carolina
			Usual Residence of Decedent		U T			July 14	, 1939 NOI	th Carolina
	ylanc		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	e Ma	cto	Delaware Sussex		Lincolr	1				1 ☐ Yes 2 🗖 No
	or 28	Director	10e. Street and Number			10f. Zip Code			0g. Citizen of What Co	•
	ath w 8 23a	ra	7 South Drive			19960			United Sta	
	ttem trem	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X No	ver in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	nispanic Origin? (Spi an, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, White	
336	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specify: W	hite
21215-0036	within 72 hours after death with the Maryland sne. than "natural", or items 23s or 28s-f show its Madical Exertinal by ricilified at	Completed	15. Decedent's Edu (Specify only highest grade		16a. De	cedent's Usual Occup	ation	ina	16b. Kind of Business/	Industry
2	thin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5+	) life	a. DO NOT use retired	d)	,,,9		
	ygier ygier her th		12		Hom	emaker	40 44-44-4-41-41	(Fine Addd)	Own Home	
and	be fill hd ott	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
چ	hould d Mei mark matic	٩	Thomas Avery Ram  19a, Informant's Name/Relationship (Ty)		19h M	ailing Address (Street			Liff Godwin City or Town, State, 2	
Maryland	nd 2 s Ith an 27 is		Robert F. Rogers			South Driv				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show amounts injury go other traumatic evant, the Medical Exercities mant by retitible at ance.		20a. Method of Disposition		20b. Place of Dis	sposition (Name of crematory or other place	-   0	Date	20c. Location - City or	Town, State
Baltimore,	Page nent o		1 XBuriai 2 Cremation 3 ☐R 1 Donation 5 ☐ Other (Specify)	emoval from State		n Memorial	Jan	. 29,	Milton, De	laware
alti	mit.		21. Signature of Funeral Service License	ρ <b>φ</b> //		ee. Name and Addre			ral Home	
<u>m</u>	88 5 8	0 0	/ fung (.	WV		10 East De	er Park D	rive -	Gaithersbu	cg, MD.20877
74			23a. Part1. Enter the disease, or compli shock, or heart lailure. List only or	cations that caused to be cause on each line	he death. Do not	enter the mode of dyir	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Lung (	Cancer					1 Year
***	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
		-	Sequentially list conditions, if any, leading to immediate	). — Due to (or as a	consequence of):		<del></del>			
	nsit	Examiner	Cause. Enter Underlying Cause (Disease or injury							
Ć.	execu n and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
8760,	cate be executed physician and the burial-transit	dical		l,						
9	± 00 €	Aedi	IF FEMALE:							_
Вох	death certifi e attending p od for use as	an/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	Fetal death	3 □Ectopic pregnancy	,		23d. Date of deli	very Day Year
0	0 0	/sici	1 ☐ Yes 2 MNo 9 ☐ Unknown	4□Pregnant at t 9□ Unknown	ime of death	5 Other (specify)			Work	Day Tou.
<u>α</u>	law requires that the death cer as been signed by the attendir 2 should be detached for use	by Physician/Me	Part II. Other significant conditions con	tributing to death bu	not resulting in the	a underlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ds,	signed of				<b>,</b>	<b>,.</b>		1X□ Ye	s 2 No 3 Pro	obably 4 Unknown
Sor	w requir been si should	iete						24a. Was a	n 24h Were au	topsy findings available
Vital Record	o ~ o	Completed						autops	y prior to death?	completion of cause of
ta	ilcien: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Death		No 1 ☐ Yes	2□ No
<u> </u>		To B	examiner? 1 ☐ Yes 2 XNo	lospital: 1 🗌 Inpatien	t 2 ER/Outpa	tient 3 DOA Oth			nce 6 XOther (Spec	Son's
n of	ding Phys h. After this funeral di	L:uc	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time		y at k?		w injury occurred	REBINGREE
Sio	Attending ir death. ector: After by the fune	atic	2 Accident investigation				Yes 2 □ No			
Division	l or Atten after deati Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injui building, etc.	y - At home, farm, (Specify)	street, factory, office		28f. Location (St. City or Town	reet and Number or Ru ı, State)	ral Route Number,
ני	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 X Certifying Phys	sician: To the best of	my knowledge d	eath occurred at the time	ne date and place	and due to the	luse(s) and manner as	etated
	24 hc 24 hc Fun etely	edical	(Check only 2 Medical Examination)	ner: On the basis of and manner stat	examination and/or	investigation, in my o	pinion, death occurr	ed at the time, da	ate and place, and due	to the cause(s)
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	Me	29b. Signature and title of certifier			29c. Licens	e number	25	9d. Date signed (Month	, Day, Year)
	6		+ Holand	D	MD	75	16/6	6	1-27-20	Y 00
			30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Typ	pe, Print)			115	
				1101 CM	L Pains	Philip	DINIT	527 01	JEY MI	1-3-11
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 4 200	32. Registra	's Signature	Sporks				

State of Maryland / Department of Health and Mental Hygiene 2004 05098 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 6:45PM ETHELYN WARD RUMLEY anuary 262004 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Boonsboro Washington

9. Birthplace (State or Foreign Country) Farney-Keedy Nursing Home
5. Social Security Number 6. Sex 7. Age (In yrs. last birthd) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye MARCH 22, Yeer) **Funeral** Days 1 □ M 2 🏋 F 243-03-3061 Yrs. 90 1913 NORTH CAROLINA Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic ayant, the Maxical Examiner must be notified at 1 ☐ Yes 2√ No Director BOONSBORO MARYLAND WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8507 MAPLEVILLE ROAD 21713 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. Specify þ 3 ∠Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) REGISTRAR PUBLIC UNIVERSITY CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ss 1 and 2 should be fi of Health and Mental H item 27 is marked ot Be MARY LOUISE MANNING WILLIAM HUTCHEN WARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2411 STATION ROAD, MIDDLETOWN, MARYLAND 21769 CAROLYN R. RITCHIE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of F. Important: If ite any injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State JAN. 30, 04 GREENWOOD CEMETERY GREENVILLE, NC \* 4 ☐ Donation \_ 5 ☐ Other (Specify) 21. Signature of Juneral Service Uceses 22. Name and Address of Facility 7606 OLD NATIONAL PIKE telly A. 21713 BAST FUNERAL HOME BOONSBORO, MARYLAND 23a. Part1. Enter in olsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEBRT FAIL DRE **Physician** · CONCIECTIVE OX disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical the IF FEMALE **BSD** 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Munknown cate has been sig. , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 👿 No ٩ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) inby 4 - Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who comple a cause of death (Item 23a) (Type, Print) KHALID M. WASEEM, M.D., 1126 OPAL COURT, HAGERSTOWN, MARYLAND 32. Agistrar's Signature State Registrar

DHMH 17 Rev 1/2001

2121

Maryland

thely Baltimore, I

P.O. Box 68760

Division of Vital Records,

ara

ORIGINAL

			1 - For State Registrar	State of Ma	aryland / Depa Ce	rtificate of I	Death	ental Hygiei Reg.	ne.2004	05099
	Physicia	an	Decedent's Name (First, Middle, Lass	st)				Date of Death     Month	Day Year	3. Time of Death
	/Medic				Yvonne Reaga				ry 30, 2004	5:00 A.M
:	Examin	er	4a. Facility Name (If not institution, give		mt D 10	46. City, Town, or	Location of Death		4c. County of Death	
			5. Social Security Number 6. S	owells Lane A	Pt. B-18 e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	tburg  B. Date of Birth	A	llegany place (State or Foreign
	Funeral Director			□ M 20X F	76 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye November		Ohio
	p.		Usual Residence of Decedent					rtovember		
	arylar show	_	10a. State 10b. County		10c. City, Town or Lo	ocation				0d. Inside City Limits 1 XYes 2 □ No
	Ba-f	Director		Allegany		1::	Frostburg			
	with t		10e. Street and Number	la Taran And D	10	10f. Zip Code		10g.	Citizen of What Cour	ntry?
	eath	erai	11. Marital Status	Is Lane Apt, B		Was Decedent of H	21532 isnanic Origin? (Spe	ecity Yes or No-	14. Race - Americ	SA can Indian
326	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at	by Funerai	1 Never Married 2 Married 3 Wildowed 4 Divorced	Armed Forces?  1 Yes 2 7  If Yes, Give Year or Dates:	10	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Rican, etc.)	Black, White, Specify:	etc.
Maryland 21215-003	2 hor	Completed	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	ation	16b	. Kind of Business/In	White dustry
218	thin 7	ple	(Specify only highest gra	College (1-4or 5	+) (Give	kind of work done of DO NOT use retired	during most of working)	ng		
7	filed wil Hygien Sther th ent, II e	Son	10		<u> </u>		Food		Res	taurant
ב	tal Hid oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Maid	den Surname)	
<u> </u>	2 should be and Mental Is marked of aumatic ev	ပ္		Roland Rog					die Calihan	
<u>a</u>	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationship (19a. LaNita McKer		19b. Maili				ty or Town, State, Zip	
	ges 1 and 2 should it of Health and Men if item 27 Is marke or other traumatic		20a. Method of Disposition	Zic-Daugillei	20b. Place of Dispo	osition (Name of			lland Md, 215 Location - City or To	
ē	Pages nent of ant: If its ury or o		1 X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specific		cemetery, cre	matory or other plac		February 0.,	532	
Baltimore,	1 E E E		21. Signature of Funeral Service Licen			Sap Veterans ( 2. Name and Addres		2004	Flintstone	Maryland
ä	Departing Department on in poore		Jus E. McKe	·					Home P.A. 8 E	. Main
			23a. Part 1. Enter the disease, or compshock, or heart failure. List only	plications that caused	the death. Do not en	ter the mode of dyin	g, such as cardiac o	r respiratory arrest,	ld.21539	Approximate Interval Between
L	Physician		Immediate Cause (Final disease or condition		(roma	of Lux	9		j	Onset and Death
	/Medical		resulting in death)	α.	a consequence of):	0	1			
	Examiner	_	Sequentially list conditions,	b						
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
_	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):			_		
68760	ificate be executed g physician and as the burial-transit			d						
89		edical		0.						
Box	res that the death certiff igned by the attending be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		⊒Ectopic pregnancy			23d. Date of delive	•
E	e deal	sicis	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant at 9□Unknown		Other (specify)			Month	Day Year
P.O.	d by t detach	Phy	9 ☐ Unknown  Part II. Other significant conditions c		ut not reculting in the		an in Bank (	22a Did tahaan	o use contribute to the	an annual of death?
ds,	The law requires that the death cert ate has been signed by the attendin page 2 should be detached for use		Part II. Other significant conditions c	orthodaling to death bi	at not resulting in the b	indenying cause give	en in Fan i.	1 🔁 Yes		ably 4 Unknown
Š	w require been sign should t	ete						24a. Was an		any findings available
Re	he lav e has	Completed						autopsy performed	prior to co	psy findings available mpletion of cause of
a	ificate or, pa	e C	25. Was case referred to medical				26. Place of Death	1 Yes 2 2	No 1 ☐ Yes	2□ No
>	ysicle s cert direct	0 B	examiner? 1 □ Yes 2♥ No	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatie	nt 3□ DOA Othe		-	6 ☐Other (Specif	v)
2	ng Ph ter th	T.	27. Manner of Death	28a. Date of Inju	y 28b. Time o			28d. Describe how in		,
Sio	endir sath. or: Af he fur	atic	1 Natural 5 Pending 2 Accident investigation	1	,		Yes 2 □ No			
Division of Vital Records,	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At home, farm, st c. (Specify)	reet, factory, office	2	28f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
_	ours a	Ce	29a. Certifier .+ Certifying Ph	vsician: To the best	of my knowledge, deat	th occurred at the time	ne date and place	and due to the service	o(s) and mass = 1 = 1	atad
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medicel Exen	niner: On the basis of and manner sta	examination and/or in	ivestigation, in my of	pinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	•		29c. License		29d.	Date signed (Month,	Day, Year)
	7		► ~ ~ ~ ~ ~ ~ ~	forms		1)0	0 33280	F	cb 2, 20	04
	1011		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,	, Print)			Α	
	nes		Sunil K.	Gupt A	625 Ken	+ Avenu	re, Lumbe	rland, M	eb 2, 20	21502
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 2 2004	//	ar's Signature	Sparks				

State of Maryland / Department of Health and Mental Hygiene 2004 05100 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY Day3, 2004 RICHARD RICHMOND 1:30 P. M **Physician** Α. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 56 219-52-0425 **X**□M 2□F MARYLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State r then "natural", or items 23e or 28e-f show the Medical Evar: 也 ar must be notified at MDALLEGANY CUMBERLAND ₩ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 624 N. CENTRE STREET U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

\*\*Nij Yes 2 in No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ALLEGANY TRANSIT BUS DRIVER permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Importent: If item 27 is marked other It any injury or other fraumatic event, Ital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be TWILA MAXINE CARDER UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)
F. WAYNE ALBRIGHT / BROTHER 12009 OLD WILLOWBROOK RD, SE, CUMBERLAND, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 02/05/2004 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State CUMBERLAND CREMATORY CUMBERLAND, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD <u> 21502</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Unk. Years **Physician** a Arteriosclerotic Heart Disease /Medical Due to (or as a consequence of): **Examiner** S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) o detached 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Tes 2X No Division of Vital 25. Was case referred to medical examiner?
1. Yes 2 □ No 26. Place of Death Check on one funeral director, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation nours after death neral Director: A filled in by the fi 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 6 To the Hospital
within 24 hours a
To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manper stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D09157 February 4,2004 and address of person who completed cause of death (Item 23a) (Type, Print)

1 Snow, M.D., Deputy M.E. - 124 W. Third Street, Cumberland, MD Paul Snow, 22. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 0 5 2004 State ocks

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Amended Item #311 - State Registrater BSR), 02-06-04, TCHD, bsr Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** FEBRUARY 3 2004 8:55PM BETTY G. STINCHCOMB /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** EASTON TALBOT TALBOT HOSPICE HOUSE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day. Year) | NOV 26 1942 9. Birthplace (State or Foreign 7 Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🕏 F MARYLAND 215-40-7530 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10b. County 10a. State r Itams 23a or 28a-f show 1 ☐ Yes XXNo TALBOT EASTON MD Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17 KENSINGTON DRIVE 21601 TISA or Itams 23a 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ▼ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 CAFETERIA STAFF SCHOOL SYSTEM other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Is marked of Pages 1 and 2 should be ment of Health and Mental ent: If item 27 is marked ANDREW L. COWLEY LOUISE SCHINDEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5391 MARLAN DRIVE, TRAPPE, MD 21673 MICHELE NAGEL/DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a, Method of Disposition cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State ō permit. Page Department of Importent: If sny injury or 4 □ Donation 5 □ Other (Specify) GREENMOUNT CEMETERY 2-7-2004 HILLSBORO, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Ustraushy C.F.S! Joseph m. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ance nea disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner na Can Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of). Examiner death certificate be executed use as the burial-tran nding physician and Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? the atter Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ should be 200 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an has page 2 X No certificate 1 ☐ Yes Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) HOSPICE No 1 🗌 Yes Certification: To this 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation filled in by the Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 5 within 24 hours a To the Funerel ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

CICIA KARL 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

Nucia and address of person wh

32. Registrar's Signa

completed cause of death (Hem 23a) (Type, Print)

arres

Goldsburg Mi 2150ld Town Rd

			For State Registrar	State of M	larylan	d / Depa <i>Cer</i>	rtment of H tificate of L	ealth and M Death	lental Hyg	giene 200	4 05 1 02	
	Physici	an	Decedent's Name (First, Middle, L.	Last) E. STEV					2. Date of Dea Month JAN •		3. Time of Death 4 8:05 P M	
	/Medic		DOROTHY	Location of Death	JAN.	4c. County of De						
	Examin	er	4a. Facility Name (If not institution, g HOLY Cross I		)		7.	Spring		MONTG		
	Funeral		-	. Sex 7. A	ge (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. B	inthplace (State or Foreign	
	Director		722-18-5864	1□M 28CIF	75	Yrs.	Months Days	Hours Min.	Nov.1	5,1928	Maryland	
and	>		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits	
Mary	o par	ō	MD Monto	gomery		Gait	hersbur	a			1 ☐ Yes 2√☐ No	
the	7.28a	Director	10e. Street and Number	3011121			10f. Zip Code	<u> </u>		log. Citizen of What C	Country?	
th with	23a o		704 Quince	Orchard F	ivd.	, #20	2 20	878		U.S.A	•	
s after dear	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Extrainer Last by Indiffed at ODE.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1	i? ≹No	_   '	Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 <mark>[3]</mark> No	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh Specify:		
d within 72 hours aff	n "natural tedical E	Completed t	15. Decedent's (Specify only highest s	Education grade completed)		(Give	lent's Usual Occupa kind of work done of OO NOT use retired,	luring most of work	ing	16b. Kind of Busines	s/Industry	
7 ± × 5	than the	Шo	Elementary/Secondary (0-12)	College (1-4o	5+)	Ho	use Kee	per		Home		
2 =	al Hyg	Вес	17. Father's Name (First, Middle, La					18. Mother's Name				
y la	Ment Barkec	2	Henry Stewa						-	ne Moore		
Mar yraind d 2 should be file	h and 7 Is n traun		19a. Informant's Name/Relationship Ann Ellis (1	Niece)							ZMDが20878 Gaithersbui	
ָר ק	Healt tem 2 other		20a. Method of Disposition	viece)	20b. P		sition (Name of natory or other place			20c. Location - City of		
	ant of the property of the pro		1 ☐ Burial 2 [XCremation 3 4 ☐ Donation 5 ☐ Other (Special Control of the Contr				'uneral		/04	Alexandr	ia, VA	
Dailling C,	Departm Importal any inju		21. Signature of Funeral Service Lice	)	when					FUNERAL   kville,	HOME, P.A. MD 20850	
P	hysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.  Immediate Cause (Final disease or condition a Pneumonia									
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_	, =	ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	Une to (or a		uanno of):						
o rou,	physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  c. Renal Failure  Due to (or as a consequence of):								Days	
	ng phy	Medic	IF FEMALE:									
The law requires that the death certifi	ed by the attending detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1								elivery Day Year	
Cos, T	been signed by	ğ	Part II. Other significant conditions	s contributing to death	but not resi	ulting in the u	nderlying cause give	on in Part I.		_	to the cause of death?  Probably 4 □Unknown	
		Completed							24a. Was a autops perfor 1 ☐ Yes	sy prior to		
OI VIIA	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of Deat			-	
5 4	rahis	- To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of In	jury	ER/Outpatien 28b. Time of		at □ Nursing Ho		ence 6 Other (Sp	ecify)	
Attending	th. : Afte	atlon	Natural 5 Pending 2 Accident investigat	(Month, E	lay Year)	Injury		:? /es 2 ☐ No				
DIVISION PROPERTY.	after dea i Director	Certification:	3 Suicide 6 Could not 4 Homicide determine	ad 286. Place of I	njury - At ho etc. <i>(Specif</i> )	ome, farm, str	eet, factory, office		28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,	
IQ solitation Had	To the Functal Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)  Certifying 2   Medical Ex	Physician: To the best taminer: On the basis and manner:	of examinat	wledge, death tion and/or in	n occurred at the tim vestigation, in my op	ie, date and place, pinion, death occuri	and due to the c red at the time, d	ause(s) and manner a late and place, and du	as stated. le to the cause(s)	
F	withir To th	Ĕ	29b. Signature and title of certifier				29c. License			29d. Date signed (Mor		
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	1			AWAY F	0 130	x 83	Print) 819 Cta	eithers	long	2-2- mo20	883,	
	Sta Regist		FEB 0 6 2	32. Regis	strar's Signa	ture	Sparks	/				

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	Physici		Decedent's Name (First, Middle, to Burton		J.	tpi k.k.	S1	atnick			2. Date of De Month Februar	Da	ay 200	ear 4	3. Time (	of Death A M	
	/Medic Examir		A ME NO AN AN AND AND AN AND AN AND AN					4b. City, Town, o		4c. County of De Montgor							
	Funeral Director		5. Social Security Number 148–30–3325	Sex 1⊠M 2□F		(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Bir (Month, Da April 2	ıy, Year	)	Cour	olece (State htry) Jerse		
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgo	mery		10c. City,	Town or Lo							1	Od. Inside C	City Limits	
	h with the 23e or 28e	Funeral Director	10e. Street and Number 5104 Bradley B	10f. Zip Code d 20815						10g. Citizen of What United Sta							
920	be filed within 72 hours after death with the Maryland hal hygiene. Id other then "natural", or itema 23e or 28e-f show event, the Medical Examiner court by motified at	by Funer	11. Marital Status  1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dec Armed Fo 1 X Yes If Yes, Gi Year or D	orces?	58-19	1 1	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 No	tispanic ( an, Mexic	an, Puerto I	city Yes or No Rican, etc.)	)-	14. Race - Black, Specify:	White,	etc.		
Maryland 21215-0036	1 within 72 ho piene. r then *natur Ine Medical.	Completed by	15. Decedent's (Specify only highest g Etementary/Secondary (0-12)	Education rade completed)  College (	1-4or 5-	+)	(Give lite. L	tent's Usual Occup kind of work done DO NOT use retire 1tant	during me	ost of workin	ng		Gind of Busi				
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	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	one)	hysician: To the miner: On the band mani	asis or e	examination	dge, death and/or inv	occurred at the timestigation, in my o	pinion, de	ind place, areath occurre	d at the time, o	date and	d place, and	due to	the cause(s	)	
10	) <del>+  </del>	-	29b. Signature and title of certifier	Bu	2010	y M	Q	29c. License D0728					te signed (A				
			30. Name and address of person who James A. Brown, M	.D. 9707	of dea	ath (ttem 23 dical	Cent	er Drive	, Ro	ckvill	le, MD	2085	50				
	Sta Registra		31. Date filed (Month, Day, Year) FEB 0 6 20		egistrar	's Signature	6	Sparks	/								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dorothy SHAPIRO Month 6:03 P 2004 February 1, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) July 22, 1 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F Director 83 1920 Illinois 345-40-9148 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at ances. 1 ☐ Yes 2 No **Funeral Director** Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 11308 Tara Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Rece - American Indian, 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No white þ Specify 3√2 Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 3 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David M. Leifer Rose Leifer 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20854 Nancy Moses, Daughter 11308 Tara Road, Potomac, MD 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 02/04/04 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Lakeworth, FL Lakeworth Memory Gardens 21. Signature of Fundal Service Licensee Torchinsky Hebrew Funeral Home, Inc. 254 Carroll St., NW, Washington, DC 20012 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** RINgni " NE WEER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760. the attending physician Physician/Medical the IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 740 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 0 2/2No 2 🗌 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient ER/Outpatient 8 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No death. after death Director: / 2 Accident investigation the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Unive M.D 31. Date filed (Month 32. Registrar's Signature Registrar

		-	For State Registrar	State	of Maryland	/ Depa <i>Cer</i>	rtment of F tificate of	leaith and iv <i>Death</i>	nental Hygi Re	iene 2	004	0510	5
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		Physician Robert Scott							01	31	2004	12:02 A <sup>M</sup>	
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, o	r Location of Death		4c. Cour	nty of Deeth		
			Prince George		· · · · · · · · · · · · · · · · · · ·		Cheve		-		P.G.		_
	Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 8,	Year)	9. Birthp	place (State or Foreign htry)	
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	and w		Usual Residence of Decedent  10a. State 10b. County	······································	10c. City, T	own or Lo	cation				1	I Od. Inside City Limits	
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	3a or	Funeral Director	3654 New Hamps	hire Aven	ue, N.W.		20	010		1	U.S.A.		
	death ms 2	Jera	11. Marital Status	12. Was De	cedent Ever in U.S.	13. V	Vas Decedent of H	lispanic Origin? (Sp	ecify Yes or No-		ace - Americ		_
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Division	or Attendate death	Certification:	4 Homicide deter	mined 206. Fld	ce of Injury - At home Iding, etc. (Specify)	e, tarm, str	et, factory, office		28f. Location (St. City or Town		noer or Hurz	ai Houte Number,	
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifi	er	//		29c. Licens			9d. Date sign	ned (Month,	Day, Year)	
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State of Maryland / Department of Health and Mental Hygiene 2004 05106 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician**  $\underline{A}^\mathsf{M}$ Wilmer Willis Schroebel February 2004 3:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomerv If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F Director 85 March 18, 1918 California 561-07-8743 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Director Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 or items 23a 10346 Watkins Mill Drive 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Maryland 21215-0036 WW II 1 ☐ Yes 2X No Specify. þ Specify: White 3 ☐ Widowed 4 X Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Classified Duties Department of Energy 5+ marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ies 1 and 2 should be fill of Health and Mentat H fitem 27 ie marked oth Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If tem 27 is marked any injury or other treumatic as once. Richard Schroebel Hazel Finkbohner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Schroebel / Son 316 Broadwood Drive Rockville, Maryland 20851 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. 2, 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory Alexandria, Virginia 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home DeVol Funer

10 E. Deer Park Dr. Gaither

23a. Part1. Enjerthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Myological Gaithersburg, MD 20877 Approximate Interval Between Onset and Death Physician Months /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (of as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): attending physician Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. 1 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 💢 No After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funaral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) To bribe 10 D 42452 lyupul February 1, 2004 30. Name and address of per who mpleted cause of death (Item 23a) (Type, Print) Chitra Rajagopal, M.D. 18111 Prince Philip Drive #327 Olney, Maryland 20832 31. Date filed (Month, Day, Year) FEB 0 4 32. Registrar's Signature State 2004 oaks) sener Registrar

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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events.		21. Signature of Funeral Service Licer		C	emete 22	Name and Ad	dress of Facilit	200		ilver Spr		
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4			23a. Part1. Enter/the disease, or com shock, or heart failure. List only	plications that ca	used the death.	Do not ente	or the mode of o	tying, such as	cardiac o	r respiratory arres	v <u>v v v v v v v v v v v v v v v v v v v</u>	Approxima Interval Be	ate
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	/Medical Examiner		resulting in death)		or as a conseque		rrracro						
	LAdminier	<u>.</u>	Sequentially list conditions, if any, leading to immediate		nary Ar		Disease					3	
	ted nsit	Examiner	cause. Enter underlying Cause (Disease or injury	Due to (d	r as a conseque	nce of):							
	al-tra	xar	that initiated events resulting in death) Last	c. Due to (o	r as a conseque	nce of):				<del></del>			
68760,	icate be executed physician and s the burial-transit	edlcai		d									
_	tificat g phy as th												
Вох	death certificate be executed e attending physician and id for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregnance		Ectopic pregnar	201			23d. Date of	delivery	
	0 0	sicla	in the past 12 months? 1 ☐ Yes 2 🛣 No		nt at time ol dear		Other (specify)				Month	Day	Year
<u>о</u>	that the de ed by the detached	Phy	9 Unknown										
ŝ	se un	þ	Part II, Other significant conditions of	ontributing to dea	ith but not resulti	ing in the un	derlying cause	given in Part I.		111	cco use contribute		
Ö	w requir been si should I	etec								1 Yes	2½ No 3□		
Records,	has has ge 2 s	Completed								24a. Was an autopsy	prior t	autopsy findings o completion of	available cause of
			05 Was asset of the section of							performe 1 ☐ Yes 25		? 9s 2□ No	
5	Physicien: The rithis certificate ha	o Be	25. Was case referred to medical examiner?  1 ∑ Yes 2 □ No	Hospital:		7/0	25.00	When	77-1	(Check only one)			
ō	문 는 FE	n: To	27. Manner of Death	28a. Date of	Injury 28	NOutpatient 8b. Time of	28c. In	ury at		e 5 X Residen 8d. Describe how	ce 6 □Other (Sp	pecify)	
0	Attending Ph r death. ector: After th by the funeral	atio	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	W	lork? □Yes 2□1			,,		
Division of Vital	- 00	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	280. Place 0	f Injury - At home g, etc. (Specify)	e, larm, stre	et, factory, offic	е	2	81. Location (Stre	et and Number or	Rural Route Nun	nber,
	ital or A irs after al Directed in by	Cer								City or Town,	·		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Ph (Check only one)	vsician: To the b iner: On the bas and manne	is of examination	edge, death n and/or inve	occurred at the estigation, in my	time, date and opinion, deat	d place, ai th occurre	nd due to the cau d at the time, date	se(s) and manner a and place, and d	as stated. ue to the cause(s	s)
	To the withing to the	Σ	29b. Signature and title of certifier	1/1			29c. Lice	nse number		290	. Date signed (Mor	nth, Day, Year)	
	9		1 Lu	WW			HO	005128		.	January 2	29, 2004	
			30. Name and address of person who o	ompleted cause	of death (Item 23	3а) (Туре, Р	rint)						
			Anushiravan Dadg		9715 gistrar's Signatur	Medic	al Cent	er Dri	ve,	201, Ro	ckville,	MD 2085	0
18	Stat Registra		FEB 0 2 201	)4	polici s digriatur	6	Spark	2					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar Amend Item#3p	erPHYG828 2/	aryland / i 18/04 EW	Cer	tificate of D	eaith and M Death	ciliaiiiy	Reg. N	2004	05108	
	Physici	212	Decedent's Name (First, Middle, La	st)					2. Date of De Month Jan	eath E		3. Time of Death	
	/Medic	al	Eltee T. Shockle  4a. Facility Name (If not institution, given	-	4b. City, Town, or L	ocation of Death	01	Year 2004  1c. County of Deat	12;55 P M				
1	Examin	er	Atlantic General				Berlin	Location of Death		Worcester			
	Funeral Director			COM ACIE	e (In yrs. last bii 4	rthday) Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months   Davs   Hours   Min. (Month, Day, Year)   9. Birthplace (St.						
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits	
	Maryle f sho	tor	MD Worcest					1⊠Yes 2 No					
	r 28a	irec	10e. Street and Number	n	10f. Zip Code			10g. (	Cilizen of What Country?				
	23a c	raiD	8730 Lewis Rd.	21811				U.S.					
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturst", or liems 23s or 28s-f show avent, the Medical Exemple must be maillised at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1  Yes 2 X  tf Yes, Give Year or Dates:	<b>XN</b> 0 1		Vas Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 No	cify Yes or Ni Rican, etc.)	0-	14. Race - Ame Black, White Specify: Bla	e, elc.		
5-0	72 h	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a	(Give I	ent's Usual Occupati kind of work done du DO NOT use retired)	ion iring most of workin	g	16b.	Kind of Business/	Industry	
121	e filed within al Hygiene. I other than '	Completed	Elementary/Secondary (0-12) 7th	College (1-4or	5+)		age Colle	ector			City Gov	ernment	
d 2	m - 0 5	Be C	17. Father's Name (First, Middle, Last	)			1	18. Mother's Name	(First, Middle	, Maide	en Sumame)		
ylar		TO E	Herbert F. Shock					Maggie Fa					
Mar	and and aum		19a. Informant's Name/Relationship (				g Address (Street an			-		Tip Code)	
	lan Heal		Betty Mae Shockle 20a. Method of Disposition	ey/wrre	20b. Place o	of Dispos	Lewis Rd.	D	ale		Location - City or	Town, Slate	
Baltimore,	t of # 10		1 Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci		St. Pa	aul aict	natory prother place) United Church C	om 1/6/20	004	De	erlin, M		
alti	mit. Pa partmen portant: y injury Ce.		21. Signature of Fulleral Service Lice		MELLIC		Name and Address	of Facility	ral Ho	- DE	LILIT IVE		
8	Ded me yes		1700			16	18 West R	d. Salis	sbury.	MD	21801		
			23a. Part 1. Edier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Between Onset and Death Consequence of the cons										
18	Physician /Medical												
	Examiner		Pedrald Dioderal Iller										
蒙		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as		27 (47)							
	ecuter and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	of):									
68760,	be ex ician burial	ai E	resulting in death) Last Due to (or as a consequence of):										
687	tificate be executed ig physician and as the burial-transit	edicai		_ d									
O. Box	The law requires that the death certify the has been signed by the attending I agge 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant al 9 Unknown	2 Fetat death		Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year			
Vital Records, P.	uires that signed by Id be deta	by	Part II. Other significant conditions	contributing to death b	ut not resulting i	in the un	derlying cause given	in Part I.		cco use contribute to the cause of death?			
COL	s been si	Completed							24a. Was		24b. Were au	topsy findings available	
R		Com			/		autops perforr						
/ita	Attending Physician: Thrideath. r death. sctor: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of Death	(Check only	one)			
of	Physic this cral dire	- To	1 Yes 2 No	28a. Date of Inju		utpatient Time of		4   Nursing Horr	e 5 Resi		6 □Other (Spec	cify)	
ion	rding F th. : After s funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Da		Injury	28c. Injury a Work? M 1 🗆 Ye	es 2 □No			•		
Division	i or Attendii after death. Director: A	Certification:	3 Suicide 6 Could not be determined	arm, stre	eet, factory, office	2	8f. Location ( City or To		et and Number or Rural Route Number, State)				
	Hospita 24 hours Funeral tety filled	Medical C		nysician: To the best hiner: On the basis o and manner st	f examination ar								
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. License r				ate signed (Month	o, Day, Year)	
•			· My	Physician	`		D536	12		1-	1-04		
067			30. Name and address of person who	completed cause of control 97	Ja He a	(Type, I	D536 hway Dr Sports	Berlin	MO	21	811		
	Sta Registr		31. Date filed (Month, Day, Year) .JAN 0 5	2004 32. Registr	ar's Signature	5	Sporks						

04-00766 3.K.S DUSTIN E. SMITH

		1 - For State Registrar	State of N	-iai ytanu	Ce	rtificate	of E	Death			Reg. No.	004	05109
Physici	an	Decedent's Name (First, Middle, L								2. Date of De Month JAN .	Dav	004	3. Time of Death 0219 P M
/Medi		Dustin Edward		ar)		4b. City, 1	Town or	Location	of Death	UALV	-	inty of Death	
Examir	ner	NORTH ARUNDEL H		" /				RNIE				IE ARUI	
Francisco .				Age (In yrs. la	st birthday)	If Under		If Under		8. Date of Bir	th		place (State or Foreign intry)
uneral irector		213-21-3756	1 <b>∑</b> M 2□F	17	Yrs.	Months	Days	Hours	Min.	(Month, De			intry) MD
v)		Usual Residence of Decedent		/		l				0000	, 1500		
I il ism 2/18 marked other than hatural, or itams 29 or 289-18 now or other traumatic event, the Madical Examiner russ to unfilled at		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
T S	cto	MD Anne Ar	undel				Lot	hian					1 ∑ Yes 2 □ No
20 8	Oire	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	intry?
Tan Tan	Funeral Director	5816 Independen					20					USA	
	une	11. Marital Status	12. Was Deceder Armed Force	s?	. 13.	Was Decede If Yes, spec	ent of His ify Cuban	spanic Ori n. Mexicar	igin? (Sp. n, Puerto	ecify Yes or No Rican, etc.)	- 14. F	Race - Ameri Black, White,	
	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give			1 🗆 Yes 2	No X	Specify:			Spe	cify: TaTi	nite
	d be	15. Decedent's	Year or Dates	s:	160 Dago	dent's Usua	I Coouna	tion			16h Kind o	f Business/Ir	
	Completed	(Specify only highest g	rade completed)		(Give	kind of wor DO NOT us	k done di e retired)	uring mos	t of work	ng	10D. Killa o	i Dusiiless/ii	loustry
	Ĕ	Elementary/Secondary (0-12)	College (1-4o	or 5+)		Stud					ні	.gh Scl	hoo1
		17. Father's Name (First, Middle, La.	st)			Doge		18. Mothe	er's Name	(First, Middle,			
	To Be	William Edv	rard Smith	Tr.					Susa	n Franc	es Wor	sham	
	-	19a. Informant's Name/Relationship		7 01.	19b. Maili	ng Address	(Street a			I Route Numbe			n Code)
any injury or other trau		Susan Smith/Mothe	er		5816	Inder	oende	ent I	ane,	Lothia	n, MD	20711	
othe	-	20a. Method of Disposition		COL	ce of Dispo	sition (Nam	e of	1		Date		on - City or T	own, State
, o		1 XBurial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec		te l		rialGa		·	/31/	2004	Dunkir	k, MD	
any injury poce.		21. Signature of Funeral Service Lic		501		2. Name and							Home D A
any in		$\rightarrow (G, \omega)$	00		P	J Box	430	. Dur	ıkirk	ymona-w	754	merar	Home, P.A.
the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (ui a	as a conseque	ince of).	t wi	and	of I	nead	)			Onset and Death
detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal d at time of dea	leath 3[	Ectopic pre						Date of delive	ery Day Year
90	by P	Part II. Other significant conditions	contributing to death	but not result	ing in the u	nderlying ca	iuse giver	n in Part I.			N-4		he cause of death?
	ted									1 🗆 1	es 2500	3 ☐ Prot	oably 4 Unknown
	Completed									24a. Was autop	sv	prior to co	ppsy findings available impletion of cause of
	Son										rmed? 2 ☐ No	death?	2 □ No
diector,	Be	25. Was case referred to medical examiner?							of Death	Check only o	ne)	70000	
5	2	1 X Yes 2 □ No	Hospital: 1 ☐ Inpa		R/Outpatier	t 3( <b>X</b> DO)	A Other	4 Nu	irsing Ho	ne 5 ☐ Resid	lence 6 🗆 🤇	Other (Specif	<b>(</b> y)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		27. Manner of Death  1 □Natural 5 □ Pending 2 □ Accident investigati 3 ☑ Suicide 6 □ Could not	on Jan 27	200 4	8b. Time or Injury	РМ	Be. Injury : Work?	?	No	28d. Describe h	et sh	2 to	al Route Number,
i	Certification;	4 ☐ Homicide determine	building,	etc. (Specify)	1 -		011100			City or Tox	m, State)	el .	
completely illed in	Medical C	29a. Certifier 1 Certifying F (Check only one) 1 Medical Ex	Physician: To the besaminer: On the basis and manner:	st of my knowl	edge, deat	occurred a vestigation,	it the time	e, date an inion, dea	d place, th occurr	and due to the	cause(s) and	manner as s e, and due to	Pain MD tated. o the cause(s)
comp	Me	29b. Signature and title of certifier	200-0-	Mn		29c.	C.C	number .M.E			29d. Date sig		Day, Year) 2004
		30. Name and address of person wh	completed cause of										
		Tasha 2 Greent	erz M.D	, 1	111 P€	enn St	reet	, Ba	ltim	ore, Ma	ryland	21201	L
Sta	ate	31. Date filed (Month, Day, Year)	32 Regis	strar's Signaty	re								

			1 - For State RegistrarAMEND #23 PE	State of Marylar					nd Mental H	ygiene Rea. No	_/FI 11 11	05110
			Decedent's Name (First, Middle, Last)	K 1111 2/3/04	COLLE				2. Date of D	eath		3. Time of Death
	Physicia		Tanney	Settle	r				FEBRU.	ARY	y Yeer 2 2004	1217 PM
	/Medic Examin	_	4e. Fecility Name (If not institution, give s	street and number)		4b. City,	Town, or I	Location of	Death	4c.	County of Death	
			CIVISTA MEDICAL	CENTER			LATA				CHARLES	
	Funeral Director		5. Social Security Number 215–26–0424 6. Sex		last birthday)  3 Yrs.	ff Under Months	1 Year Days	Hours	Min. 8. Date of E Month, 1 September	irth Pay Year) 23,	9. Birth 1920 Vir	oface (State or Foreign ginia
	p ,		Usuel Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or Lo	reation					1	10d. Inside City Limits
	ehov	5	10.400		dorf	, oation						1 Tyres 2 □ No
	28a-f	Director	Maryland Charles  10e. Street and Number	Wal	uori	10f, Zip	Code			10a. Cit	izen of What Cour	ntry?
	M or and	흐	2000 Amber Leaf Pla	ace T-3			602			1 -	USA	
	should be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or iteme 23a or 28a-f ehow marked other than "natural", or iteme 23a or 28a-f ehow marke event, Ita Madical Examin	Funeral		12. Was Decedent Ever in U	J.S. 13.	Was Deced	lent of His	spanic Origi	n? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race - Americ Bfack, White,	
9	after or Ite	Full	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2	1	Specify:	T dente though, etc.,		Specify: Bla	
00	ural',	d by	3 Widowed 4 Divorced	Year or Dates:						1 405 16		
21215-0036	"natu	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usua kind of wor DO NOT us	k done di	uring most o	of working	16b. K	ind of Business/In	dustry
12	filed withi Hygiene. other than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Labor					Nav	al Ordin	ance
0	Hyg other	a	17. Father's Name (First, Middle, Last)					18. Mother	s Name (First, Midd	le, Maiden	Sumame)	
ılar	Mental Arked o	To B	Elsie	Settler			]	Flore	nce	F	lynn	
lan	2 should and Men Is marke		19a. Informant's Name/Relationship (Ty			•			or Rural Route Nurr			
≥ ()	s 1 and 2 of Health a item 27 ls other trau		Agnes E. Settler/		2000 Place of Dispo			t PI:	Γ−3 Waldoı Date	-	aryrand ocation - City or To	
Baltimore, Maryland	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic 800.0.	1	20a. Method of Disposition  1 ▼Burial 2 □ Cremation 3 □ R  *4 □ Donation 5 □ Other (Specify)		John's	matory or or	ther place	em 2,	/7/04		dict, Ma	
Balti	permit. Departrimports any inju		21. Signature of Funeral Service License	MO132		2. Name an			ome P.A.	Aquas	co, Mary	land
	*		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea	th. Do not en	ter the mode	e of dying	, such as c	ardiac or respiratory	arrest,		Approximate fnterval Between
	Physician		Immediate Cause (Finaf disease or condition	PNEUM	WIB	Are	272	1205	And El	TU	Chric	Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	quence of):							
	Examiner		Sequentially list conditions,	CHRONE	215	SNY	2.4	ALL	MARK			
	ed isit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec RESPIRATORY		'ס בי						
	death certificate be executed the attending physician and of for use as the burial-transit.	Examiner	that initiated events resulting in death) Last	Due to (or as a consec		KL						
8760,	cate be ex physician the buria	dlcal E		d								
9	ificating phy as the	led										
XO	eath certific attending p	Physician/Me	23b. was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		⊒Ectopic pr	egnancy				23d. Date of defive	ery Day Year
O. B	ne dea the att	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of of 9☐ Unknown	death 5[	Other (sp	ecity)				MOUTH	Day 16a1
9	by the		Part fl. Other significant conditions con	otributing to death but not re	sulting in the I	indertving c	alisa diva	n in Part I	23e. Die	d tobacco	use contribute to t	he cause of death?
Records,	es De	d by	Tatti. Otios significant conditions on	mileting to death parties.	outing in the	moony mg o	2000 g.10			Yes 2		- 1
COL	- D 70	Completed							24a. W	as an	24b. Were auto	opsy findings available
Re	The law ate has b page 2 sl	dmo							pe	topsy rformed?	death?	ompletion of cause of
Vital	sician: Th certificate rector, pag	O	25. Was case referred to medical					26. Pface of	1 ☐ Yes of Death (Check onli		1 163	2010
>	ys	To B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DO	Othe	r: 4 🗆 Nur:	sing Home 5 🗆 Re	sidence	6 □Other (Specia	fy)
n of	ng Ph fter th neral		27. Manner of Death 1 ☑ Naturaf 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 2	8c. Injury Work	at ?	28d. Describ	e how inju	ry occurred	
sio	Attending ir death. ector: After by the fune	catic	2 Accident investigation			М		′es 2□N		(0)		
Division	ial or Attending Pt s after death. al Director: After the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of fnjury - At h building, etc. (Speci	nome, farm, st ify)	reet, factory	, office			(Street ar own, State	nd Number or Run e)	al Houte Number,
	tospit 4 hour funera ely fille	edical C		sician: To the best of my kn ner: On the basis of examin and manner stated.								
	To the h within 2 To the f	Med	29b. Signature and title of certifier	and mainer stated.		290	. License	number		29d. Da	te signed (Month,	Day, Year
	F≩Fö		La	12 Ln	$\sqrt{}$	D	206	520		K	2/2/	04
0			30/Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type	12	200	ノムフ				
1	B		GEORGE H WATHE	N MD 11345	PEMBR		SOU	ARE	SUITE 10	)2 W	ALDORF	MD 20603
		ate	21 Date filed (Month Day Year)	32. Résistrar's Sign	nature	boart	9					
	Reaist	15		The state of the s		1						

Tanney Settler

		1 - For State Registrer 1. Decedent's Name (First, Middle, Las		land / Depa	artment rtificate	of Health of Death	and Mental H	Reg. N		
Physic /Med Exami	ical	Glen Oscar SOUDE	RS street and number)			own, or Location	Januar of Death	9 0	c. County of	
Funera Director		Washington County 5. Social Security Number 219–12–2109 6. Se		yrs. last birthday) Yrs.	If Under 1	agerstor Year If Under Days Hours		irth Day, Year	Washi 924	ngton Birthplace (State or Foreig Country) Maryland
1213-UU36 within 72 hours after death with the Maryland ene. then 'natural', or items 23e or 28e-f show the Maryland and Maryland Examiner man by mortified at	Director	Usuel Residence of Decedent  10a. State 10b. County  Maryland Washin  10e. Street and Number  18301 Manor Chur	gton	e. City, Town or Lo		ode 21713		10g. C	itizen of Wha	10d. Inside City Limit
IdryIdna ZIZIS-UU30 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene Is marked other than "natural", or Items 23a or 28a-1 show eumstic event, the Madical Examiner mans be notified at	ed by Funeral Director	11. Marital Status  1 Nøver Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ∑	nt of Hispanic Or y Cuban, Mexicai ☑ No Specify:	igin? (Specify Yes or N n, Puerto Rican, etc.)		Black, Specify:	American Indian, White, etc. White
d Z1Z15 filed within 72 Hygiene. other then "net	Completed	15. Decedent's Edi (Specify only highest grace Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usual ( kind of work DO NOT use borer	done during mos retired)		1	railro	ad
aryland standard be file and Mental Hy marked oth	To Be	17. Father's Name (First, Middle, Last)  Elmer Souders  19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Mailir	ng Address (S	Le	er's Name (First, Middle eona Smith er or Rural Route Numb			ite, Zip Code)
2 5575		Glen D. Souders —  20a. Method of Disposition  1 🖾 Burial 2 Cremation 3 🗆 6	Removal from State	112 Ob. Place of Dispo cemetery, crem	02 Chr sition (Name natory or othe	istian (	Circle, Hag	erst 20c. L	own, ]	Md . 21742 y or Town, State
Dattimore, in permit. Pages 1 am Department of Heall Important: If Item 2 any injury or other 2008.		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Euneral Service Licens		Manor Cer	. Name and	Address of Facili	1/31/04  MINNICH Lvd., Hagers	FUN	IERAL I	
The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law required by the attending physician and  The law required by the attending physician and the law required by the attending physician and the law required by	ilcai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events resulting in death) Last	ications that caused the ne cause on each line.  a	cerebra nsequence of): efens, nsequence of):		of dying, such as	cardiac or respiratory a	arrest,		Approximate Interval Between Onset and Death 12 hrs  flears
at the death certifice by the attending ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pro 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregi Other (speci				23d. Date of Month	delivery Day Year
law requires that as been signed by 2 should be deta	by	Part II. Other significant conditions co.	ntributing to death but not		nderlying caus	se given in Part I.		tobacco Yes 2		te to the cause of death?  Probably 4 Unknow
	e Completed	25. Was case referred to medical				00 01	1 ☐ Yes	psy ormed? 2 No	prior	e autopsy findings available to completion of cause of h? Yes 2 \( \) No
	0 8	examiner?	lospital: 1 Inpatient	2 ER/Outpatien	a ∃ DOA	Ott	of Death (Check only strong Home 5 Resi		6 Other /	Speciful
After tune	Certification; T	27. Manper of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c.	Injury at Work? 1 Yes 2 1	28d. Describe	how inju	ry occurred	
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely tilled in by the funerel		4 Homicide determined  29a. Certifier 12 Certifying Physics	28e. Place of Injury - building, etc. (Sp.	knowledge, death	occurred at t	he time, date an	City or To	wn, State	) and manne	r Rural Route Number,
To the Ho within 24 I To the Fu completely	Medical	(Check only 2 Medical Exami	ner: On the basis of exam	nination and/or inv	estigation, in	my opinion, deal	th occurred at the time,	date and	d place, and	due to the cause(s)
SAL O		30. Name arroyaddress of person who co	impleted cause of death (	(Item 23a) (Type, 1	pans	Rd,	Boonsboro	MI	2/7	13
COLUMN TWO IS NOT	ate rar	31. Date filed (Month, Day, Year) JAN 29 2	32. Redistrar's S	ignature:	bere					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Richard Wayne Smith lanuai /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Washington county Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 14, 1938 Maryland 8. Date of Birth (Month, Day, January 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1⊠M 2□F 66 Director 217-30-6198 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Hagerstown Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 U.S.A. 16817 Alcott Road Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. White 1 Never Married 2 Married 2☐ No "natural", or Specify: Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than Tractor Trailer Driver Trucking Company 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be it of Health and Mental Eva V. Grams Charles A. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16817 Alcott Rd. Hagerstown, Maryland 21740 V. Ann Smith/Wife 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 31,04 Hagerstown, Maryland permit. Page Department o Important: If any injury or 2005e. Rest Haven Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 uucla A 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onsel and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) hou /Medical Due o (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of). r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to/death but not resulting in the underlying cause given in Part I. ģ ed bluods 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Yes 25 2 No 1 ☐ Yes 1 TYes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 1 Inpatient 2 K EP Outpatient 1 Tes 3 DOA Certification; To this funeral Manner of Seath 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of dertifier 30. Name and address of person who comple ed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 2 Registrar

December Name   Frest, Motion, Last   Harrold   Russell   Schaidt   Schaid				For State Registrar	State	of Marylai	nd / Depa <i>Cer</i>	artment of F	lealth and Death	Mental Hygie	ene 200	4 05113
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Specify only implies grade complained   Specify only implies grade   Specify only	36	urs after d	by Fun	1 ☐ Never Married 2 Marri	ed 1X7Yes	orces? 2 □ No ive WW				to Rican, etc.)	Specify:	
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And the proposed and provided and positions of the proposed and provided and positions of the proposed and positions of the pr	Ba	Depriment of the population of		Kulut (	? Adu	-1		404 Deca	atur Str	eet, Cumbe	rland, MI	21502
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25. Was case referred to medical examiner?	ŏ	ith cei tendir ir use	an/N	23b. Was decedent pregnant				Ectopic pregnancy				
25. Was case referred to medical examiner?		e dea the at ned fo	sici	1 ☐ Yes 2 ☐ No			death 5□	Other (specify)			Month	Day Year
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26. Place of Death (Check only one)  27. Menger of Death 1 Natural 28. Place of Death (Check only one)  28. Injury at Work?  M 1   Yes 2   No  28. Location (Street and Number or Rural Route Number, City or Town, State)  28. Place of Death (Check only one)  28. Injury at Work?  M 1   Yes 2   No  28. Location (Street and Number or Rural Route Number, City or Town, State)  28. Place of Death (Check only one)  28. Injury at Work?  M 1   Yes 2   No  28. Location (Street and Number or Rural Route Number, City or Town, State)  28. Place of Death (Check only one)  28. Death of Injury (Month, Day Year)  28. Place of Death (Check only one)  28. Death of Injury (Month, Day Year)  28. Place of Death (Injury one)  28. Death of Injury (Month, Day Year)  29. Death of Injury (Mon			Con							performe	d?   death?	
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3/IVA  Jerus Turner  D0060396  02/02/04  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  FARID MURSHED, 1126 Opal Court, Hagerstown, MD 21740:  State  31. Date filed (Mopula Qay, Year)  32. Registrar's Signature		Hospita 24 hours Funeral stely fillex		(Check only 2 Medical	Exeminer: On the I	pasis of examin	lowledge, death ation and/or inv	occurred at the tir restigation, in my o	ne, date and place pinion, death occi	e, and due to the cau urred at the time, date	se(s) and manner a a and place, and du	s stated. e to the cause(s)
3/IVA  Jerus Turner  D0060396  02/02/04  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  FARID MURSHED, 1126 Opal Court, Hagerstown, MD 21740:  State  31. Date filed (Mopula Qay, Year)  32. Registrar's Signature		o the	Me		2110 11701			29c. Licens	e number	290	I. Date signed (Mon	th, Day, Year)
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State 31. Date filed (Mopth Qay, Year) 32. Registrar's Signature		2/12/1		30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type,	1 3 -	/ /			1
State 31. Date filed (Modern Lay, 1987)		nas		FARID	MUR	SHE	0.	1126_0pg	Court	Hagereton	n_ MD 21	740
				31. Date filed (Month, Day, Year)	2004 32.	Registrar's Sign	nature /			601300W	*** **** ***	, T

State of Maryland / Department of Health and Mental Hygiene For State Registra 05114 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day 14 **Physician** 2004 JANUARY WILLIAM DONALD SWEENE 8:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY 13301 WINCHESTER ROAD, LOT AA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, MAY 12 Sex M 2□F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** MARYLAND 84 Director 217 01 1562 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28e-f show Examiner must be notified at 1 Yes 2 No Director CUMBERLAND MARYLAND ALLEGANY 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 13301 WINCHESTER ROAD, LOT AA 21502 U.S. death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: WW II Specify 3 ☐ Widowed 4 ☐ Divorced WHITE "natural", permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "naturany injury or other treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GLASS CRANE OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE WILLIAM SWEENE ELIZA SHARPLESS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) COLLEEN SWEENE / WIFE 13301 WINCHESTER ROAD, LOT AA, CUMBERLAND, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) SUNSET MEMORIAL PARK 1/17/04 CUMBERLAND, MD 21. Signature of Funeral Se 22. Name and Address of Facility once. 60 W. MAIN STREET SOWERS FUNERAL HOME, P.A. FROSTBURG. MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MALIGNANT MESOTHELIOMA **Physician** How disease or condition 5 Month resulting in death) /Medical Due to (or as a consequence of) Examiner ASBESTOSIS UNKNEWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): burial-1 P.O. Box 68760. ed by the attending physicien detached for use as the buria Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown s been signed by the should be detach Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown COLITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 Yes 22 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 2 Accident 5 Pending death. investigation 1 Yes 2 No after death 6 Could not be determined 3 Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26907 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit S. Sidhu, M.D., 925 Bishop Walsh Road, Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32, Registrar's Signature State parkel Registrar

		·		ate of Maryla	nd / Depa		lealth and	Mental Hygi	_	05115
	Physici	an	1. Decedent's Name (First, Middle, Last)  Mabel C. Taylo	or				2. Date of Death January	28, 2004	3. Time of Death 1935 M
/	/Medic Examin	al	4a. Facility Name (If not institution, give street Calvert Memorial Ho	and number)		4b. City, Town, or Prince	Location of Deat	h	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (in yrs 93	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Birth Cou Miss	place (State or Foreign intry) SISSIPPI
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo					10d. Inside City Limits
	8a-f st	Director	MD Calvert		Prince	Frederic	ek			1 ☐ Yes 2 ☒ No
	as or 2	Dire	10e. Street and Number 1625 Mint Court			10f. Zip Code 206	678	10	g. Citizen of What Cou USA	intry?
36	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, I're Medical Examinat must be mullified at	by Funerai	11. Marital Status  1 Never Married 2 Married 1  If	/as Decedent Ever in t med Forces? ☐ Yes 2 ☒ No Yes, Give ear or Dates:		Was Decedent of H if Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S in, Mexican, Puer Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White Specify: B]	
Baltimore, Maryland 21215-0036	vithin 72 hou ne. han *natura n Medical E	Completed	15. Decedent's Education (Specify only highest grade con	1	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	rking	6b. Kind of Business/Ir	
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mor			1 ☐ Burial 2 ☑ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cirer ee Crem		200		Clinton, N	
Balti	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licensee	R					Home Calve l Owings,	•
			23a. Fart Enter the disease, or complication shock, or heart failure. List only one ca	use on each line.				•		Approximate Interval Between Onset and Death
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,092	eath certificate be executed attending physician and for use as the burial-transit	cai Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
89	certificat nding phy use as th			yes, outcome of pregr					23d. Date of deliv	erv
P.O. Box	it the death by the atter tached for u	Physician/Med	in the past 12 months?	□Live birth 2 □ Fet □ Pregnant at time of □ Unknown		Ectopic pregnancy Other (specify)		·	Month	Day Year
	ires tha signed d be de	٥	Part II. Other significant conditions contribu	ting to death but not re	•	nderlying cause give			cco use contribute to t	
Vital Records,		Completed	Recent Stroke Acute on Chro		emip nal	legia. Failu	UTE.	24a. Was an autopsy performe 1 ☐ Yes 2 €	prior to co	opsy findings available impletion of cause of
	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	tal: 1 Inpatient 2	ER/Outpatien	t 3C DOA Othe		ath <i>(Check only one)</i>	ce 6 □Other (Speci	(v)
n of	m 0 0			a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	at c?	28d. Describe how		77
Division of	ten Seat For: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28	e. Place of Injury - At the building, etc. (Spec	nome, farm, str ify)		Yes 2 □ No	28f. Location (Stre City or Town,	et and Number or Aur State)	al Route Number,
_	Hospita 4 hours Funere ety fille	edical Ce	29a. Certifier (Check only one)	n: To the best of my kn On the basis of examin and manner stated.	owledge, death ation and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the cau irred at the time, dat	se(s) and manner as s e and place, and due t	stated. o the cause(s)
<b>)</b>	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	c hero		29c. License	50653	3	1/29/20	
	,		30. Name and address of person who completed in the second	ted cause of death (Ite	m 23a) (Type,	Print) GYA	TO C-	SURA	NA 70	751
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra's Sign	ature L	And H. 2	D'ECE!	17/2	- 40	()/
	Registi	rar	FEB 0 4 2	1947 Julieur	as Di	MATTERIAL				

		-	For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of Hea rtificate of De	Ith and Menta ath	l Hygie <sub>Reg.</sub>	ne 200	05116
	Dhamini		1. Decedent's Name (First, Middle,	Last)			2. Date Mon	of Death	Day Y	3. Time of Death
	Physicia /Medic	ai -	ROBERT N.	TAYLOR,		T		JARY 2	26, 200	
	Examin	er	4a. Facility Name (If not institution,  MEMORIAL HO	give street and numb DSPITAL	eer)	4b. City, Town, or Local  CUMBERL			4c. County of	EGANY
_	Funeral				Age (In yrs. last birthday	If Under 1 Year If U	Jnder 24 Hrs. 8. Date	of Birth	9	). Birthplace (State or Foreign
	Director		230-04-9410	1 M 2□F	43 Yrs.	Months Days Ho	ours Min. (Mor	nth, Day, Ye	960	Couintry) MARYLAND
pu	≥ 33		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation	···			10d. Inside City Limits
Aaryla	show and an	ō		SHIRE	RIO	A				1 □ Yes 2 → No
the A	28a-	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of Wha	at Country?
h with	23a o 181 Lv	ai D	ROUTE 29			26755			U.S.A	•
21215-0036 Id within 72 hours after death with the Maryland	ial Hygiene. od othar than "neturel", or items 23a or 28a-f shov event, the Medical Evaninar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ▼ Divorced	12. Was Decede Armed Force ad 1 Tes 2 If Yes, Give Year or Date	<b>X</b> №	Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 ☐ No Sp	nic Origin? (Specify Yes exican, Puerto Rican, e pecify:	or No- tc.)		American Indian, White, etc. WHITE
5-0 72 ho	netur	Completed	15. Decedent' (Specify only highest		16a. Dece (Give	dent's Usual Occupation with kind of work done during DO NOT use retired)	g most of working	166	. Kind of Busin	ness/Industry
121 within	P P P	id m	Elementary/Secondary (0-12)	College (1-4	Or 54)	DO NOT use retired)  RPENTER			CONST	RUCTION
a)	Hygie thar t		12 17. Father's Name (First, Middle, L	ast)			Mother's Name (First,			
a a	ked o	To Be	ROBERT N.	TAYLOR,	SR.		HILDA GA	Y C	ARTER	
Maryland	Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me.	-	19a. Informant's Name/Relationsh	_		ing Addrass (Street and I			•	ate, Zip Code)
_ =	ealth in 27 i	1 8	TUESDAY N.	SIONS /	-	OFFICE BOX				26851
Baltimore,	0	1 8	20a. Method of Disposition 1  Burial 2 Cremation	3 □Removal from St		matory or other place)	Date			ty or Town, State
tim	tment rtent:		'4 □Donation 5 □ Other (Sp			MATION SERV		004	WINCHE	ESTER, VA
Balt	Department Importent: Importent: I any injury o		21. Signature of Funeral Service L	Lyocher	ich u		JNERAL HOME	·		LE, WV 26851
			23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on eac	the line.	iter the mode or dying, so	icii as cardiac or respire	itory arrest,		Interval Between Onset and Death
	nysician /Medical		disease or condition resulting in death)		LE TRAUMA W. r as a consequence of):	LIH MIDICAL	COMPLICATI	ONS		22 DAYS
E	xaminer		O service the first and distance	h	,					
	. =	ner	Sequentially list conditions, if any, leading to immediate cause. Liner Unorlying Cause (Disease or injury	Due to (or	r as a consequence of):					
ecuta	ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to /or	r as a consequence of):					
8760,	ician		,	Due to (or	as a consequence on.					
87 87	ohys the	dical		d.						
Box	by the attending partnershed for usa as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birt	nt at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	•
O te	ed by detach	Phy	Part II. Other significant conditio	ns contributing to dea	th but not resulting in the	underlying cause given in	Part I. 23e	. Did tobac	co use contribu	ute to the cause of death?
ords, P.	baan signed I	d by						1 🗌 Yes	2 □ No 3	☐ Probably 4 X Unknown
Division of Vital Records,	hasb je 2 st	Completed		-				a. Was an autopsy performed Yes 2X	d? prio	ore autopsy findings available or to completion of cause of ath?  Yes 2 \( \subseteq \) No
ital	certificata	Bec	25. Was case referred to medical examiner?				Place of Death (Check			
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on C		ion:	27. Manner of Death  1 □ Natural 5 □ Pending investig		Injury 28b. Time Injury 2004 3:00	Work?			cident	1
/ision	death. ctor: A y the fu	Certification;	3 Suicide 6 Could n	ot be 28e. Place o	of Injury - At home, farm, s		28f. Loc	ation (Stree	t and Number	or Rural Route Number,
Div	d in b	erti	4  Homicide	building	g, etc. <i>(Specity)</i> <b>Road</b>	•		r or Town, S <b>r Run</b>	-	n. Cnty, WV
]	vithin 24 hours after death  To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical I	g Physician: To the b Examiner: On the bas and manne	pest of my knowledge, dea sis of examination and/or i	ith occurred at the time, d nvestigation, in my opinio	late and place, and due	to the caus	e(s) and mann	ner as stated.
T e	within 2 To the complet	Me	29b. Signature and title of certifier	1	//	29c. License nu		_	•	Month, Day, Year)
	12			1_//		D09157		Jā	an. 26,	2004
_			30 Name and address of person	who completed cause	of death (Item 23a) (Type	Print)	P. mbr. 1-	n J A	1 21	560
7	nrs		31. Date filed (Month, Day, Year)	1) - Leggetof	JV, G - Ja4 W gistrar's Signature		Cumparla	10, 1V	1D 2/	X) 2
	Sta Regist	ate rar	FEB 0 5 2004		as Sugnavie	porks				

		1 - For Unpended Iteri#2 Registrer  1. Decedent's Name (First, Middle, Li						-		2. Date of De			3. Time of Death
Physic	ian		•	_						Month	Day	Yeer	
/Med		William Edwa  4a. Fecility Name (If not institution, gi			-	4b. City, To	wn or l	Location	f Death	Januar		2004 nty of Death	7:06A M
Exam	iner	Easton Memorial F	_	7		_		Location	Death		Tal	-	
- Funera				ige (In yrs. la:	st birthday)	Easto		If Under 2	4 Hrs.	8. Date of Bir			place (State or Foreign
Funera Directo		214-70-5995	182 M 2□F	6	Yrs.	Months D	Days	Hours	Min.	8. Date of Bir (Month, Da Dec. 15			place (State or Foreigr ntry) rland
		Usual Residence of Decedent								Dec.19	الرودو	rialy	Tanu
rylan how		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
e Ma	cto	Maryland Caroli	ne		Dento	n							1 ☐ Yes 2 ☐ No
를 50 분	Director	10e. Street and Number				10f. Zip Co	ode				10g. Citizen	of What Cou	ntry?
ath w	ra	304 Fountain	Ave.				1629				USA		
ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or Itema 23a or 28e-f ahow or other traumatic avent, the Maxical Exertit at marken retilied at	Completed by Funeral	11. Marital Status	12. Was Deceden Armed Forces	2	. 13. \	Vas Deceden f Yes, specify	t of His Cuban	panic Orig , <b>Me</b> xican,	in? (Spe Puerto	ecify Yes or No Rican, etc.)	)- 14. P	lace - Ameri lack, White,	
rs aft	γF	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 1 If Yes, Give Year or Dates			I□Yes 2☐	No	Specify:			Spe	cify:	7 1
hou	edt	15. Decedent's E		•	16a. Decec	lent's Usual C	Occupat	tion			16b. Kind of		lack
in 72	piet	(Specify only highest gi	rade completed)	.5.)	(Give	kind of work of OO NOT use i	done du	ırina most	of worki	ng	TOD. KING OF	0031116332111	dustry
iene r tha	E	Elementary/Secondary (0-12)	College (1-4or	5+)	Mec	hanic	/ Ma	anite	nanc	e.e	Plavi	ex	
e filed I Hygi other	BeC	17. Father's Name (First, Middle, Las	t)				-			(First, Middle,			
should be find Mental Is marked of umatic ave	To 8	William Edwar	d Wilson	. Sr.				Hi1	da M	L. Turp	in		
and A is ma		19a. Informant's Name/Relationship			19b. Mailin	g Address (S	treet ar			I Route Numb		m, State, Zip	Code)
and 2 salth a n 27 is		Wendy H.Wilson	/ Wife		304 1	Founta:	in A	ve	Den	ton, Mar	rvland	21629	
of He of He fiten		20a. Method of Disposition 1 D Burial 2 ☐ Cremation 3 [	□Romoval from State		ce of Dispos	sition (Name in atory or other	of		0	ate	20c. Locatio		own, State
Pant neu		` 4 ☐Donation 5 ☐ Other (Speci			ng Gr	ove Cer	mete	ery¦0	1/29	/2004	Dentor	,Mary	land
permit. Depertr Importe any inje		21 Signature of Fundral Service Line	and of		22	Name and A	Address	of Facility	Funo	rol Uor			
20 E = 9		114 Juger				426 D	over	Str	eet,	ral Hor Eastor	n,Maryl	and 2	1601
		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that cause one cause on each	ed the death. line.	Do not ente	o ebom ent re	of dying,	, such as c	ardiac o	r respiratory a	rrest,		Approximate Interval Between
nysician		Immediate Cause (Final disease or condition	Sarcoid	csis									Onset and Death
/Medica		resulting in death)	Due to (or a	s a conseque	ence of):								
Examine		Sequentially list conditions.	b										
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ite be executed lysicien and ne burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or a	s a conseque	nce of):								
te be ex ysicien ie burial	cal E		Due to (or a	s a conseque	rice or).								
physic the l		•	d										
The law requires that the death certification has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcom	e of pregnanc	cy						234 [	Date of delive	201
eath atter I for L	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal d	leath 3	Ectopic pregr Other (specif						Month	Day Year
that the de led by the a detached t	ysi	1 Yes 2 No	9☐ Unknown			, - 111-1 (-)	·//						
res that igned b be deta	by Pt	Part II. Other significant conditions	contributing to death	but not result	ing in the un	iderlying caus	sa given	n in Part 1.		23e. Did to	obacco use co	ntribute to th	ne cause of death?
sejur Sigr	d b									101	Yes 2 No	3 🗌 Prob	ably 4 Unknown
w require been si should b	Completed			-						24a. Was	an 24h	Were auto	psy findings available
e has	Ę									autop	rmed?	prior to con death?	mpletion of cause of
certificate rector, pag		25. Was case referred to medical						00 81		1/2 Yes		1 X Jes	2 No
this certific	To Be	examiner? 1	Hospital:	ient 2127EI	R/Outpatieni	3□ DOA	Other			(Check only one 5 ☐ Resid		(Cit	
ar this eral dii	1	27. Manner of Death	28a. Date of Inj (Month, D		8b. Time of		Injury a	at		28d. Describe h			y)
ith. :: After e funer	tio	1 Natural 5 Pending 2 Accident investigation		ay Year)	Injury	М	Work? 1 ☐ Ye	es 2⊡N	0				
after death.  Director: A  In by the fu	ffica	3 ☐ Suicide 6 ☐ Could not to determined	250. Place of it	njury - At hom	e, farm, stre	eet, factory, of	ffice		2	8f. Location (S	Street and Nur	nber or Rura	il Route Number,
to the hospitel or stateding Prysician: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification:	4   Homicide	building, e	etc. (Specify)						City or Tox	vn, State)		
within 24 hours a To the Funerel t completely filled		29a. Certifier 1☐ Certifying P	hysician: To the bes	t of my knowl	edge, death	occurred at the	he time	, date and	place, a	and due to the	cause(s) and r	nanner as st	ated.
n 24 ne Fu	Medical	(Check only a Medical Exa	miner: On the basis and manner s	of examinatio tated.	n and/or inv	estigation, in	my opir	nion, death	occurre	ed at the time,	date and place	and due to	the cause(s)
within 2 To the	ž	29b. Signature and title of certifier	/ //			29c. Li	icense r	number			29d. Date sign	ned (Month,	Day, Year)
			1 hs			O.C	.M.E	Ε.			January	25.	2004
		30. Name and address of person who	completed cause of	death (Item 2	23a) (Type, 1								
		MARY	4. CIPPL	Em	)	111 P	enn	Stre	et,	Baltim	ore, Ma	rylan	d 21201
Sta		24 Date Class (March Day March	30 Dague	trar Signatur	**				-			_	
S Regis	ate	31. Date filed (Month, Day, Year)	32. negisi	irai a Signatui	10								

		1 - For State Registrar			artment of Health an rtificate of Death	Reg	ene .No. <b>200</b> 4 0511
Physicia	an	1. Decedent's Name (First, Middle, La				2. Date of Death Month	Day Yeer 3. Time of Death
/Medic Examine		Catherine V 4a. Fecility Name (If not institution, given	irginia re street and numb	Whetzel	4b. City, Town, or Location of D		09 2004 6:50 A A
LXamiii	C1	MEMORIAL HOSPITAI			CUMBERLAND		ALLEGANY
Funeral Director			Sex 7. 1 □ M 2 1 F	Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year		
yland		10a. State 10b. County		10c. City, Town or Lo	ocation		10d. Inside City Limits
be filed within 72 hours after deeth with the Maryland tial tyglene. ed other then "naturel; or iteme 23a or 28a-f ehow event, the Medical Examinar rural be notified	Director	WV Hampsh	ire	Green S	pring		1 ☐ Yes 2 → No
with the or 2		10e. Street and Number			10f. Zip Code	10g	. Citizen of What Country?
me 23	Funeral	P.O. Box 7	12. Was Decede	nt Ever in U.S. 13.	26722 Was Decedent of Hispanic Origin?	? (Specify Yes or No-	USA 14. Race - American Indian,
or its	Fur	1 Never Married 2 Married	Armed Force 1 Yes 2 [ If Yes, Give	No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Po	uerto Rican, etc.)	Black, White, etc.
id 2 should be filed within 72 hours aff the and Mental Hygiene. 27 is marked other then "naturel", or traumatic event, the Medical Exemi	ed by	3 Widowed 4 Divorced	Year or Date	s:	1 Yes 2 No Specify:		Specify: White
n "nal	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working 161	b. Kind of Business/Industry
giene giene er the	Com	Elementary/Secondary (0-12)	College (1-4c	or 5+)	Postmaster		Mail
e d a b	Be	17. Father's Name (First, Middle, Last,				Name (First, Middle, Mai	- other and
should be and Mental s marked o umatic eve	၉	Alston David:		405 44 33		la Dayton	
s 1 and 2 should if Health end Mer item 27 is marke other traumatic		Lawrence S. Whe			Pow 7 Canada Sumber or		
of Hea of Hea of Hea of Hea of Hea	ì	20a. Method of Disposition		20b. Place of Dispo	Box 7 Green Sp	Date V11/04	Location - City or Town, State
	П	1		Forest	Glen Glen Emetery	/11/04 Gr	een Spring, WV
permit. Peg Department important: I eny injury o onge.	1	21. Signature of Funeral Service Jacer	isee	22	. Name and Address of Facility	kcKee Funera	al Home Hamp.LLC
40 E • 0	-	23a. Part 1. Enter the disease, or come	tyles		lo. E. birch Lar	ne Komnev. W	N 26757
Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	. Meta	ine.	^	ell Can	Approximate Interval Between Onset and Death
cate be ohysicie the bur	dical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	c Obstruc- is a consequence of):	tive Pulmona	ry Disea	se 10 years
w requires that the death certific been signed by the attending p should be detached for use as it	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
es that gned b		Part II. Other significant conditions of	ontributing to death	but not resulting in the un	derlying cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?
Ben si						1 XYes	2 No 3 Probably 4 ☐Unknown
icate hes b	Completed					24a. Was an autopsy performed 1 Yes 2	
s certil	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗙 No	Hospital: 1 1 Inpat		Oth	eath (Check only one)	
g Phy ler this leral o	- 1-	27. Manner of Death	28a. Date of Ini (Month, D		28c. Injury at Work?	Home 5 Residence	
endin sath. or: Aff	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		ay Year) Injury	M 1 Yes 2 No		
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2.	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	building, e	njury - At home, farm, stre tc. <i>(Specify)</i>		City or Town, Sta	•
Hosp 24 hou Fune etely fil	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the bes iner: On the basis and manner s	oi examination and/or invi	occurred at the time, date and pla estigation, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as stated.  Ind place, and due to the cause(s)
To the Mithin Somple		29b. Signature and title of certifier	and mariner s	(3)	29c. License number	29d. [	Date signed (Month, Day, Year)
		1 Menle	· ·		00060478		RUARY 09 2004
8		30. Name and address if person who d			Print)		2004
					02 CUMBERLAND, M	ARYLAND 21	502
State Registrar		31. Date filed (Month, Day, Year)		ar's Signature	Bosile		-

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dev Vear Month **Physician** 02 11 2004 7:10 PM Beatrice Lillian Willick /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner 7218 New Cut Road Kingsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Funeral Days 1 ☐ M 2 💢 F Vrs Director 88 10/10/1915 Maryland 212-18-3527 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 21 No Funeral Director Baltimore Kingsville 10g. Citizen of Whet Country? 10f Zip Code 10e. Street end Number filed within 72 hours after death with thygiene.

Hygiene.

ther than "natural", or flems 23a or? 7218 New Cut Road U.S.A. 21087 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 X No If Yes, Give 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education .(Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Seamstress Clothing Industry other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Department of Health and Mental important: If Item 27 is marked of any injury or other traumatic even Clarence Mast Lillian Carter 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ethel B. Fauth (niece) 7218 New Cut Road - Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fork U.M. Church Cem. 02/14/2004 Fork, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licens 11750 Belair Road - Kingsville, MD as 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** DIABETES MELLITUS Immediate Cause (Final disease or condition resulting in death) zivic<del>aic</del>ai **Examiner** Examiner buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieled events resulting in death) Last tEART FAILURE Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical OBSTRUCTIVE PHIMONOMY DITIONS & Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 Probably 4 Unknown burs efter death.

eral Director: After this certificete hes been signed ifflied in by the funeral director, page 2 should be det 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Tes 1 Yes or Attending Physician: Certification: To Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 21 No 5 Residence 6 □Other (Specify) 1 ☐ Yes 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title ed cause of deeth (Item 23e) (Type, Print), 5629 LONG CORNER RUAD WHITE HALLMD 2116 RAVITZIMID REBNAND 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05120 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6:00pM 29, WEINBERG January 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maplewood Park Place Bethesda Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 85 1 M 2 XF 388-12-0062 June 10 1918 Wisconsin Director Usual Residence of Decedent

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "neturel", or items 23s or 28s-1 show
any injury or other traumatic event, tra Medical Exprise arrival to a rollified at

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10a. State 10b. County 10c. City, Town or Location 10d. Ins												10d. Inside City Limits
2	Maryland	Montgom	ery	Bet	hesda	a						1 ⊠Yes 2 🗋 No
2	10e. Street and Nu	mber		^		10f. Zip Code				10g. C	itizen of What Co	untry?
2	9707 01	d Georget	own Road			2081	4			Un	ited Sta	ites
	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. W	as Decedent of P Yes, specify Cub	dispanic (	Origin? (Spec	ify Yes or No	)-	14. Race - Ame Black, White	
2	_	ried 2 Married	1 ☐ Yes 2 🔯 If Yes, Give	No		☐ Yes 2☑ No					Specify: Wh	
2	3 ∰Widowed		Year or Dates:									
ובונ	(Spec	15. Decedent's Edu cify only highest grad	ucation le completed)	16	Give k	ent's Usual Occup ind of work done O NOT use retire	during m	ost of working	9	16b.	Kind of Business/	Industry
4	Elementary/Seco	ondary (0-12)	College (1-4or s	5+)		nemaker	0)				Own Home	<b>.</b>
נ ט	17. Father's Name	(First, Middle, Last)			1101		18. Mo	ther's Name (	First, Middle,			
2	Bery1	Goldsmith						Tanya				
17	19a. Informant's N	ame/Relationship (T	ype, Print)								or Town, State, 2	(ip Code)
	Robert	Weinberg,	Son			Tanglew		Dr., B	ethesd	la,	MD 2081	.7
1/2	20a. Method of Dis	position Cremation 3 1	Damousi from State	20b. Place cemet	of Disposi ery, crema	ition (Name of atory or other pla	сө)	Da	te	20c. l	_ocation - City or	Town, State
		5 Other (Specify		Mt. L	ebano	on Cemet	ery	Feb.	1, 200	4	Adelphi,	Maryland
		uneral Gervice L.cens	/		Tr.	Name and Addre	II _	In second Ti	uneral	Но	me Inc.	
Torchinsky Hebrew Funeral Home, Inc. 254 Carroll St. NW, Washington, DC 2											0012	
23a. Part. The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres, shock, or heart failure. List only one cause on each line.  254. Carroll St. NW, Washinston, DC 20012 Approximately Cause (Final Cause (Fina												Approximate Interval Between Onset and Death
	disease or condition	on	$P_{ii}$	Dinos	10x	4 /	a	lin	P			Onset and Death
	resulting in death)		Due to (or as	a consequence	of):	J						
	Sequentially list co	onditions,	b. PCL	1 Kins	SUL	1	)is	ease				
0	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	mmediate erlying	Due to (or as	a consequence	e of):							
9	that initiated event resulting in death)	S	C. Due to (or as	a consequence	a of):							-
ii H			000,10 (0. 20	2 0011004001101	3.7.							
2			d									
Z	IF FEMALE: 23b. Was deceder	ot orognast	23c. If yes, outcome								23d. Date of deli	very
2	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnanc Other <i>(specify)</i> _	у				Month	Day Year
32	9 Unknown		9□ Unknown									
7	Part II. Other signi	ificant conditions co	intributing to death b	ut not resulting	in the und	derlying cause gr	ven in Pa	rt I.	23e. Did t	obacco	use contribute to	the cause of death?
ב כ	Dem	Lentia							10	Yes 2	200 3□Pr	obabiy 4 Unknown
		_							24a. Was		24b. Were au	topsy findings available completion of cause of
5									autor perfo	rmed?	death?	
ע	25. Was case refe	rred to medical					26. Pla	ace of Death (		/_	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20110
2	examiner?	No	Hospital: 1   Inpatie	ent 2 ER/C	outpatient	3 DOA Ott		,			6 ☐Other (Spec	cify)
	27. Manner of Dea	th	28a. Date of Inju (Month, Da	ry 28b.	Time of Injury	28c. Inju Wo			d. Describe l			
פופ	1 Natural 2 Accident	5 Pending investigation	,	,,	,,		Yes 2	□No				
ermication	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj building, et	ury - At home, c. (Specify)	farm, stree	et, factory, office		28	If. Location (3 City or Tox	Strøet a vn, Sta	ind Number or Ru te)	ral Route Number,
)												
Medical	29a. Certifier (Check only one)	Certifying Phy	vsician: To the best iner: On the basis of and manner st	f examination a	ge, death und/or inve	occurred at the trastigation, in my	me, date opinion, d	and place, an leath occurred	d due to the	cause(: date ar	s) and manner as nd place, and due	stated. to the cause(s)
Ž	29b. Signature and	title of certifier				29c. Licen:	se numbe	er C		29d. D	ate signed (Month	n, Day, Year)
	<b>&gt;</b> ///)	erlin	- 110	mu	M	D	35	141			1301	04
	30. Name and add	lress of person who o	ompleted cause of c	leath (Item 23a	(Type, P	rint)			N		,	7

State

Registrar

12

MERLTA

FEB 02

MD

32. Registrar's Signature

			1 - For State Registrar	State of Maryla	nd / Depa			Mental Hvo	_	
	a	J.F	1. Decedent's Name (First, Middle, Last)	-			· ·	2. Date of Dear	th	3. Time of Death
	Physici /Medio		EUGENE	VIRGINIA	WOOD			JAN.	31, 200	1:20 A M
j	Examir		4a. Fecility Name (If not institution, give st	reet and number)		4b. City, Town,	or Location of Death		4c. County of	
П			LAUREL REGIONA	L HOSPITAL		LA	UREL		PRINCE	GEORGES
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days		8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		422-20-9904	100	Yrs.			JUNE 1		MISSÍSSIPPI
	and and		Usuel Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	danyl f sho	ō	MD MONIMOON							1 X Yes 2 □ No
	the 1	Director	MD. MONTGOM  10e. Street and Number	<u>EKY</u>	SIL	VER SPRII	NG	1	0g. Citizen of Wha	at Country?
	3a or		12725 LAYHIL	L RD. #101		209	206			•
	death ms 2	Funeral		2. Was Decedent Ever in L	J.S. 13. V		Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No-	U . S	• A • American Indian,
9	after or Ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 XNo				o Rican, etc.)	Black,	White, etc.
8	ral', c	i by	3 ☐ Widowed 4 📉 Divorced	If Yes, Give Year or Dates:		1□Yes 21XXNo	Specify:		Specify:	WHITE
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Hems 23s or 28s-f show he Madical Examirer must be notified at	Completed	15. Decedent's Educa (Specify only highest grade		16a. Deced	dent's Usual Occup	pation during most of wor	kina	16b. Kind of Busin	ness/Industry
2	hen.	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I		during most of word d)			
	Hygie Hygie other t	ပိ	17. Father's Name (First, Middle, Last)	4		COUNSEL		- /First Middle A		UNIVERSITY
and	ntal hed od	Be		DOORE				ne (First, Middle, M	·	
Ž	should nd Men marke umatic	ဥ	EUGENET  19a. Informant's Name/Relationship (Type	BOOZE	10h Mailin	a Addrasa (Cirani	and Number or Ru	ARY	MONTGOM	
Maryland	d 2 s th an t7 ls		WILLIAM E. POLK/							
ē	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of	LE LA.#10		20c. Location - Cit	
OL.	Pages nent of int: If Ik		1 Burial 2 XCremation 3 Rei	moval from State		natory or other pla	1			
Baltimore,	orter	1	21. Signature of Funeral Service Licensee	1		Name and Addre	TORY 2-3-  ss of Facility	-2004	RIVERDA	LE, MD.
m	permit. Deportr Importe any nju		M.M. Chan	where we	CI	HAMBERS I	UNERAL HOLLAND AVE	OME & CRI	MATORIUM	M, P.A.
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ations that caused the dear	th. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arre	ost,	Approximate
	Physician		Immediate Cause (Final disease or condition	CORONARY AR	TEDV D	TCFACE				Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consec		LOEADE				
	Examiner		Suggestially list over this year	ARTERIOSCLE	ROSIS					SEVERAL YRS.
	ס #	Examiner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injury the conditions of t	Due to (or as a consec	juence of):					
	ecute and trans	cam	cause (Disease or injury that initiated events resulting in death) Last	HYPERTENSIO						
760,	ate be executed nysicien and he burial-transit			Due to (or as a consec	(uence of):					
00	physic the l	edical	d.							
9 ×	death certificat e attending phy id for use as th	/Me	IF FEMALE: 230	. If yes, outcome of pregna	ancv					
Вох	atten for u	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Fete 4 ☐ Pregnant at time of d	death 3	Ectopic pregnancy Other (specify)	1		23d. Date of Month	Day Year
o.	the c y the	ysi	1 ☐ Yes 2X No 9 ☐ Unknown	9□ Unknown		(3,000,1)				
o.	g g g	by PI	Part II. Other significant conditions contr	ibuting to death but not res	ulting in the un	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
Records,	w requires been sign should be		CARDIAC ARRYHTH	MIA				1 ☐ Yes	s 2 No 3	Probably 4XUnknown
ဝ္ထ	law re	Completed	ATRIAL FIBRILAT	ION				24a. Was an		e autopsy findings available
	The la	E O						autopsy	ed? deat	
Vital		a)	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 h (Check only one		Yes 2□ No
	di S	10 B	examiner? 1 Yes 2 No	spital: 1 Inpatient 2 X	ER/Outpatient	t 3 DOA Oth		ome 5 Resider		Specify)
n of			27. Manner of Death 1 Xatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe how		
0	Attending or death.  ector: After by the fune	atic	2 Accident investigation		,,		Yes 2 □ No			
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · At he building, etc. (Specif.	ome, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number o State)	r Rural Route Number,
	Hospitel or A 24 hours after Funerel Directely filled in by									
	H 42 H 88	edical	29a. Certifier (Check only one)  1	ian: To the best of my kno r: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and maillier stated.		29c. Licens			d. Date signed (M	
)	+ ≥ + Ø		ALA INOL	pew m.	<b>&gt;</b> .		1294			
		+	30. Name and address of person who com	pleted cause of death (Item	23a) (Type F		.1274		red. 2	2, 2004
			ABDUL NAYEEM, M	,			., SUITE	100, LAI	REL, MD.	20724
	Sta	e	31. Date filed (Month PB Year)	32. Registrar's Signa		1	4			
	Registra	3 F	0 - 200	Theren	67	100.4				

			For State Registrer	State of	Marylar	id / Depa	artment of H rtificate of L	lealth a	and Me	ntal Hyg	iene 2	004	05122
	Dhusiair		1. Decedent's Name (First, Middle							. Date of Dea Month	Day	Year	3. Time of Death
,	Physicia /Medic	al	Sophia	Wojtk			1			anuary		004	7:25A M
2	Examin	er	4a. Facility Name (If not institution				4b. City, Town, or					ity of Death e Arui	201
			Crofton Conval 5. Social Security Number		Renabi 7. Age (In yrs.		If Under 1 Year	ofton		Date of Birth			
	Funeral Director		152-24-1388	1□M 2√F	93	Yrs.	Months Days	Hours	Min. No	Date of Birth (Month, Day OV • 23	1910	New Cour	place (State or Foreign htry) Jersey
			Usual Residence of Decedent										
	irylan ihow	_	10a. State 10b. County			ry, Town or Lo	ocation					1	0d. Inside City Limits
	Ba-f s	cto		e Georges	Bo	owie							1 □ Yes 2√2 No
	vith th	Dire	10e. Street and Number	- Duiss			10f. Zip Code 20715			,	Og. Citizen o Unite		-
	sath v	erai	12401 Kembridg	e Drive	dent Ever in U	S 13	Was Decedent of Hi	isnanic Ori	igin? (Specif	ly Yes or No-		ace - Americ	
	fter de	Funeral Director	1 Never Married 2 Marr	Armed For	ces? 2 👿 No		If Yes, specify Cuba	in, Mexicar	n, Puerto Rio	can, etc.)		lack, White,	
3	hours after death with the Maryland tural', or Items 23e or 28a-f show al Exard an must be notified at	þ	3X Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	e		1 ☐ Yes 2 X No	Specify:	;		Spec	eify: Wh:	ite
21215-003	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "natural", or Items 23s or 28s-f show evant, the Medical Evaluation must be notified at evant.	Completed	15. Decedent (Specify only highes	's Education t grade completed)		16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during mos	st of working		16b. Kind of	Business/In	dustry
2	within 72 ene. then "nal	mpi	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT use retired nstress	) -			Garm	onte	
	filed wi Hygien other th ant, the		9 17. Father's Name (First, Middle,	l ast)		Sear	uscress	18. Mothe	er's Name (/	First, Middle, i			
and	d be f	Be C	Konstanty Bars							asiewi		,	
Maryland	s 1 and 2 should be if Health and Menta item 27 is marked othar treumatic e	ဥ	19a. Informant's Name/Relations			19b. Maili	ng Address (Street a					n, State, Zip	Code)
	ad 2 27 is r tre		Leo Clark	(Son)		1240	1 Kembrid	ge Dr	. Bo	wie, l	Maryla	nd 20'	715
altimore,	of Hea		20a. Method of Disposition	2 Dameus from 5	20b. I	Place of Disponentery, cre	osition (Name of matory or other place	e) ] <sub>1</sub>	Dat Februar		20c. Location	n - City or To	own, State
Ĕ	Pages Tent of I ant: If its ury or o		1 ☐ Burial 2 【Cremation `4 ☐ Donation 5 ☐ Other (S <sub>i</sub>		Che		Cremation (	ntr.	2004		Cheste		
Balt	permit. Pages Department of Important: If it any injury or once		21. Sign to of Cunera, Service	Licensee	M00982		2. Name and Addres 14 Bestgat			s Fune: napoli:			
Į	Physician		23a. Pert 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that conly one cause on e	ach line.	1	ter the mode of dying						Approximate Interval Between Onset and Death
6	/Medical		resulting in death)	Due to (	or as a consec								3
	Examiner		Sequentially list conditions,	b	Dy	Sph	agia						day
	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to	or as a conside	(uence or):							
	sician and burial-transit	xar	that initiated events resulting in death) Last	c. Due to (	or as a consec	(uence of):						_	
760,	tte be executed lysician and ne burial-transit	cai		d.									
89													
Вох	death certifica e attending ph ed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1 ☐ Live b	come of pregn irth 2 ☐ Feta		☐Ectopic pregnancy	,				Date of delive	ery Day Year
о. Ш	0 0 0	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregn 9□Unkno	ant at time of o	death 5[	Other (specify)					NOTES!	Day Tour
<b>Q</b>	t t	Ph.	Part II. Other significent condition	ens contributing to de	eath but not res	sulting in the u	underlying cause give	en in Part I	ı.	23e. Did to	bacco use co	ntribute to the	ne cause of death?
ds,	uires tha signed d be det	d by	Dem	nentia						1 🗆 Y	es 2 140	3 🗆 Prob	ably 4 Unknown
Soc	w requir been si should	Completed							- 5	24a. Wasa	n 24b	. Were auto	psy findings available
Re	he lav e has age 2	шc								autops perform	med?	prior to co death? 1  Yes	mpletion of cause of 2□ No
Vital Record		0	25. Was case referred to medical		***************************************			26. Place	e of Death (	Check only or	2 0 10 1		
	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ 110			] ER/Outpatie	nt 3 DOA Othe	өг: 4 <b>Ш</b> М	ursing Home	5 Reside	ence 6 🗆 O	ther (Specif	(y)
0 0	ding Ph th. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date of (Mont	of Injury h, Day Year)	28b. Time o Injury	Work		i i	d. Describe h	ow injury occ	urred	
Sio	Attending ir death. actor: After by the funer	cati	2 ☐ Accident investignment in	not be	af taine. As b			Yes 2		f Location (S	troot and Num	nhar or Purs	Il Route Number,
Division of	or Attendate death Diractor:	Certification:	4 Homicide determ	ined 200. Flace	ng, etc. (Speci	fy)	reet, factory, office		20	City or Town		nber or rigit	THOUSE NUMBER,
_	Hospital 4 hours Funeral ely filled	edical Ce	29a. Certifier 1 Certifyir (Check only one) 2 Medicel	g Physicien: To the Examiner: On the ba	best of my knoasis of examination	owledge, dea ation and/or in	th occurred at the time	ne, date an pinion, dea	nd place, and ath occurred	d due to the c at the time, d	ause(s) and r late and place	manner as s e, and due to	tated. o the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifie	$ \alpha$			29c. License	e number		2	9d. Date sign	ned (Month,	Day, Year)
	->-0		1 Hours	K LL	1 -		()3	58	48		Feb	2, 1	2004
•			30. Name and address of person	who completed caus	e of death (Ite	m 23a) (Type	Print) efe	n se	Ha	Gan	n bai	115 m	Dalosy
	Sta		31. Date filed (Month, Day, Year)	2 2004 32. R	egistrar's Sign	ature	brooks		)		•		
	Registi	GI.			- Condition		130						

1-(	)797		1 - For Unpended Iten#2.	State of M Ba,27,28a-f,	larylan Per ME	d / Depa ,G82 <b>%</b> e/	artment	of H	ealth a	and M	lental Hyg	jiene 2	004	0512	3
			1. Decedent's Name (First, Middle, La								2. Date of Dea Month	th		3. Time of Death	_
	Physic /Medi		Christophe Gl	enn Willia	ams						JANUAR	Y 29	, 2004	1420 P N	Α
<i>f</i> :	Exami		4a. Fecility Name (If not institution, giv 701 RACE STREET	e street and number	7)		4b. City, T			of Death			unty of Death	ER	
1	Funeral	Г	5. Social Security Number 6. S	6ex 7. A		last birthday)	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or Foreig	in
	Director		214-32-0140	2UF	38	Yrs.					Dec. 5,	1965		many	
	and		Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	Od. Inside City Limits	
	dary!	ō	MD Dorche	ster		,,		mhr	idae					1 X Yes 2 □ No	
3	28a-	rect	10e. Street and Number	Deci			10f. Zip (		rage			On Citizon	of What Cour		_
Y	3a or	ō	701 Race St.				101. 2.0	3000	2161	3		-		iti y i	
0	death with the Maryland ms 23a or 28a-f show rould be confilled at	Funeral Director	11. Marital Status	12. Was Deceden		S. 13. V	Vas Decede	ent of Hi			acify Yes or No- Rican, etc.)		S.A. Race - Americ	an Indian.	
9	after or Item	F	1 ☐ Never Married 2 ☑ Married	Armed Forces				,			Rican, etc.)		Black, White,	etc.	
8	ral', c	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	Yes 2	M No	Specify:			Sp	ecify: Whi	te	
21215-0036	within 72 hours after ene. then *natural', or ite	Completed	15. Decedent's Education (Specify only highest gra	ducation		16a. Deced	lent's Usual kind of work	Occupa	ition	t of worki	na	16b. Kind	of Business/Inc	dustry	_
2	ithin 18.	dr.	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT use	retired,	)		,,,g				
7	lygier her ti		12				syste	ems a					nputers	5	_
and	be filed ntal Hygid ed other	Be	17. Father's Name (First, Middle, Last) Ronnie William								(First, Middle, i				
$\frac{3}{2}$	should ind Men i marke umatic	2									iane Vir				_
Maryland	C/ G = 6	1	19a. Informant's Name/Relationship ( Christiane Willia	**		4					l Route Number		wn, State, Zip	Code)	
	1 and Health em 27 khar tr	-	20a. Method of Disposition	ams moth	20b. P	lace of Dispos	sition (Name	a of			ambride		21613 on - City or To		
JO.	Pages nent of I int: If it		1 Burial 2 Cremation 3	Removal from State	CE	emetery, crem	atory or oth	ier place							
altimore,	artme artme ortan injury		* 4 □ Donation * 5 □ Other (Specify 21. Signature of Funeral Service Licer		Bal	isbury				2/3	/04 omas Fur	Salis	bury,	MD	_
Ba	permit. Departr Importa any inji		b /bl . 0			7	00 To	Cust	- C+	. Car	mbridge,	MD	21613	.A.	
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	plications that cause one cause on each late a.  A Tyxic Due to (or as b.  Due to (or as b.	ine. 3. due t 5 a consequ	o Plast.					r respiratory arre	est,		Approximate Interval Between Onset and Death	
,820	cate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter in Jarrying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as	·										
.O. Box 6	The law requires that the death certific thas been signed by the attending page 2 should be detached for use as:	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome  1 Live birth  4 Pregnant a	2 Fetal	death 3 🗌	Ectopic preg Other <i>(spec</i>		alir =			23d.	Date of delive Month	ry Day Year	
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions c	ontributing to death t	out not resu	ilting in the un	derlying cau	ise givei	n in Part I.			acco use o		e cause of death?	
		Completed									24a. Was ar autops perform 1 Yes 2	/	prior to com death?	sy findings available apletion of cause of 2 No	1
Vital	ysician: is certific director,	o Be	25. Was case referred to medical examiner?	Hospital:		- 11.0	_	Other			(Check only one	12.			
o	Phys r this ral di	$\vdash$	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		ER/Outpatient 28b. Time of			4   1901		ne 5 Reside 8d. Describe ho			AT SCENE	_
Division	Attending Physician: If death. Sector: After this certific by the funeral director.	Certification;	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	for Month, Da	Year)	ound lajury	8.4	Nork? Ugry		1				g over head	
118	Attendir death.	fica	3 Suicide 6 □ Could not be	1/29	jury - At hor	TO:00		office		-	8f. Location (Str				
	al or A safter il Dire	ert	4 Homicide determined	Found in						70	City or Town 11. Race. St		7)-d- 120	Cambridge,M	
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director:	edical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exem	ysician: To the best niner: On the basis of and manner st	of my know	vledge, death	occurred at estigation, in	the time	e, date and nion, death	place, a	nd due to the ca	use(s) and	manner as sta	ited	_
	To the within 2 To the complet	Me	29b. Signature and title of certifier	,			29c. L	License				_	ned (Month, E		
			Thend !	1.16:0	u.s			C	CME		J	IANUAF	RY 30,	2004	
			30. Name and address of person who d	completed cause of o	death (Item							-			-
			THEODORE NIK	ing			enn S	tree	et, B	altir	nore, Ma	rylar	d 2120	1	
* 1	Sta		31. Date filed (Month, Day, Year)	3 2004 Registr	s Signati	ure	Long	K							

State of Maryland / Department of Health and Mental Hygiene 2004 05124 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** 2: 33 PM 15 OBBY 2004 WILLIAMS JANVAR 30 /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE MARYLAND UNIVERSITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) MARYLAND 08 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 102M 20 F Months Jan. 6, 1977 alifornia 216-88-7011 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or itama 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** MDTalbot Easton 10g. Citizen of Whal Country? 10e. Street and Number 10f. Zip Code USA 21601 Road -ewistowin 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No hours after Maryland 21215-0036 1 Yes 212 No If Yes, Give Year or Dates: Specify: Specify: δ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Compet Cleaners 12 455istontPages 1 and 2 should be filed vent of Health and Mental Hygie nt: If item 27 is marked other by or other traumatic event, III other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Susan Sampson SR. Dobby Earl Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name elationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Road Easton Maryland 21601

20c. Location - City or fown, Slate Jusan Friend Baltimore. 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Chapel Cemetery, crematory or other place)

Chapel Cemeters, crematory or other places

Chapel Cemeters, crema Pages permit. Page Department of Importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA ZWEEKS /Medical Due to (or as a consequence of): Examiner EUKENIA YOUTE MELOGENOUS 2 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter for u in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. PNEUMONECTOMY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown POST Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed?

1 Yes 2 No certificate of Vital director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 this To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident 6 Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined hours after within 24 hours a To the Funeral L 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier P1656 JAN MARY 30,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAJID S BALTINGRE, MARYLLYD 22 GREE 21201 CINA 31. Date filed (Month, Day, Year) State 03 Registrar

			1 - For State Registrar	State of Ma	aryland /		rtment tificate				R	leg. No.	2001	051	25
ı	Physici //Medic		Decedent's Name (First, Middle, Lasi	Ruth	May	Wea	ant			2	Date of Dea Month FEBRU	Day		3. Time of Dea	
	Examir		4a. Facility Name (If not institution, give Saint Joseph	Medical						OWSO	n	4c.	County of Dea Ba	h ltimore	
4.	Funeral Director		5. Social Security Number 6. Se 215–12–7318	x 7. Ago ☐ M 2☐ F	e (In yrs. last I		If Under 1 Months	Year Days	Hours	Min.	Date of Birth (Month, Day, ug. 17	Year)	9. Bir Mar	thplace (State or Fol buntry) yland	reign
	death with the Maryland rms 23s or 28s-f show f intest be indiffied at	Director	10a. State 10b. County	County	10c. City, To Wes	tmins	ster							10d. Inside City Lin	
	h with t	al Dir	2130 Frizzellburg	r Road			10f. Zip 0	:ode !1158	3			_	zen <i>o</i> f What Co ted Sta		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It a Medical Evant ret must be notified at anone.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 1 1 Yes, Give Year or Dates:			/as Decede Yes, specif		panic Orig , Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- can, etc.)		4. Race - Ame Black, Whit Specify: Whi	e, etc.	
21215-0036	d within 72 ho giene. Ir than *natur Ir e Medical	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 12			(Give k	ent's Usual rind of work O NOT use O teac	done du retired)	ring most	of working			of Business	,	
Maryland	should be filed and Mental Hygi i marked other umatic event.	To Be C	17. Father's Name (First, Middle, Last) Clarence Edwin Sl						Bert	ha Ma	irst, Middle, M Ty Hahn	1			
	and 2 st salth and n 27 ls n		19a. Informant's Name/Relationship (T) Ralph F. Weant /										Town, State, 2 Ster, M	Tip Code) D 21158	
Baltimore,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 ∰urial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)			ery, crem. 7ille	atory or oth Unio	e <i>r place)</i> n <b>C</b> e	m.	200	12 04 F	Keym	ation · City or ar, Mar		
Balt	permit. Departr Importe any inji		21. Signature of Fluneral Service Licens	furis	200	13	Name and 6 Eas	Address t Ba	of Facility  ltimo	Skil re St	les Fur reet			MD 21787	7
	Physician /Medical Examiner	Jer	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, lisease or injury	ications that caused ne cause on each lin  a. CORON  Due to (or as a MYOCA)  Due to (or as a control of the control of the control of the caused on the caus	e. ARY AI a consequence RDIAL	RTER e of): INF	Y DI	SEAS		ardiac or re	aspiratory arre	est,		Approximate Interval Between Onset and Death	h
<b>68760</b> , \	The law requires that the death certificate be executed te has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a CARDI)	consequence	of):									
P.O. Box (	that the death certifics ed by the attending ph detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat		Ect <i>o</i> pic preg Other <i>(spec</i>					23	3d. Date of deli Month	very Day Year	
	w requires that been signed should be det	by	Part II. Other significant conditions col_ HYPERTENSION	ntributing to death bu	t not resulting	in the und	derlying cau	se given	in Part I.					the cause of death?	
al Reco		Completed									24a. Was ar autopsy perform 1 Yes 2	y	24b. Were au prior to death?	opsy findings availa ompletion of cause 2 📈 No	able of
r Vita	Physician this certifi al director	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	nt 2 ERVO	utpatient	3□ DOA	Other:			heck only one	*	□Other (Spec	ify)	
Division of Vital Records,	tending I leath. tor: After the funer	Certification:	27. Manner of Death  1  Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not be determined	28a. Date of Injury (Month, Day) 28e. Place of Inju	Year)	Time of Injury	M			28d.	. Describe ho	w injury	occurred	ral Route Number,	
Ď	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		4   Aomicide	building, etc	. (Specify)				date and	1	City or Town,	, State)			
	the Ho iin 24 h the Fur	ledical	one) 2 Medical Exami	ner: On the basis of and manner star	examination a	nd/or inve	stigation, in	my opin	ion, death	occurred a	it the time, da	ite and p	lace, and due	to the cause(s)	
	Son Con	Σ	29b. Signature and title of certifier Rery Pull	Hms			29c. L	icense n	iumber 15738	:9	29		signed (Month		
			30. Name and address/of person who co	mpleted cause of de			rint) DRIUE	i jin	WSOK		YLAND	1 2 1	20174		
4	Sta		31. Date filed (Month, Day, Year)		's Signature	3.0	-	A 1	The state of the s		1. la 171 4 L	- Lind	14(.1)		

State of Maryland / Department of Health and Mental Hygiene 2006

			1 - For State Registrar		,	-	rtificate of			Reg. No.	2004	05126			
	Physicia	an	Decedent's Name (First, Middle, Li     CLIADI OTTE: I		ימדממיי	. D			2. Date of De. Month	Day	Year	3. Time of Death			
	/Medic	cal	CHARLOTTE I  4a. Fecility Name (If not institution, gi		TEFIEL	ער	4h City Town o	r Location of Death	FEBRU	-	6, 2004 County of Deeth	18:45 <sup>M</sup>			
	Examin	ier	MEMORIAL HOSPITA				CUMBERLA				LEGANY				
	Funeral		5. Social Security Number 6.		e (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h	9 Birthol	ace (State or Foreign			
1	Director		220-07-6442 Usual Residence of Decedent	10 M 20 F	85	85 Yrs. Months Days Hours Min. (Month, Day, Year) Country MARYLAND									
	yland		10a. State 10b. County		10c. City, T	own or Lo	ocation				10	Od. Inside City Limits			
	Ba-fet	ctor	MARYLAND ALLEGAN	ΙΥ	FROS	rburg						1 ☐ Yes 2 X No			
	with th	Dire	10e. Street and Number	rec Cheer b	- AD	77.7	10f. Zip Code	21520			en of What Count	try?			
	na 23s	Funeral Director	11323 UPPER GEORG	12. Was Decedent	Ever in U.S.			21532	acify Yas or No		4. Race - America	an Indian.			
2	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the 27 is marked other than "natural", or itama 23a or 28a-f show other traumatic event, Ita Medical Examinat natal be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2\( \)  If Yes, Give  Year or Dates:	No		If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	i	Black, White, e				
5	72 ho	eted	15. Decedent's E (Specify only highest gi		1	6a. Dece	dent's Usual Occup	ation during most of worki	na	16b. Kind	d of Business/Ind				
7	within nne. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		DO NOT use retired HOMEMAKER	during most of worki		OMN	HOME				
	ould be filed with Mental Hygiene. arked other than atic event, Italia	e Co	8 17. Father's Name (First, Middle, Las	t)			HOPEPAKEN	18. Mother's Name	(First, Middle,						
g	should be nd Mental marked c	ToB	ARCHIBALD MacDO	NALD				CHRIST	TINA SCI	HELL					
2	1 and 2 sho Health and h tem 27 is ma other trauma		19a. Informant's Name/Relationship LINDA SMYERS /					and Number or Rura LANE, SW							
υ	permit. Pages 1 and Department of Healt Importent: if Item 2 eny injury or other once.	20a. Method of Disposition  1 XBuriai 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  FROSTBURG MEMORIAL PARK 2/9/04  FROSTBURG MEMORIAL PARK 2/9/04													
ם	permit. Departm Departm Importe eny inju		1 X Buriai 2 □ Cremation 3 □ Removal from State   Cemetery, crematory or other place)												
	- P		23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that caused	the death. I	Do not ent	er the mode of dyin	g, such as cardiac o			DOKO, TH	Approximate Interval Between			
	nysician		Immediate Cause (Final disease or condition Edistance Chanic Obstructive Pulmanday Onset and Dea												
	/Medical Examiner		resulting in death)	Due to (or as	a nsequen	ice of):				1	1.1	4000			
	1633	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Disecto (or as	a consequen	ice of):									
	outed sd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.												
Ś	rificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a consequence of):											
	cate b physic the b	Medical	•	d		-				1					
٠ ٢	nding use as		IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome					-	23	3d. Date of deliver	v			
5	w requires that the death ce been signed by the attendii should be detached for use	Physician/	in the past 12 months? 1  Yes 2 No 9 Unknown	1  Live birth 4  Pregnant at 9  Unknown			Ectopic pregnancy Other (specify)					Òay Year			
'n	s that gned b	by Pl	Part II. Other significant conditions	contributing to death bi	ut not resultir	ng in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use	e contribute to the	cause of death?			
5	equire equire ould b								1 🗆 Y	es 2 🗆	No 3 Proba	bly 4 Unknown			
2	a lawin has be e 2 sh	ompleted							24a. Was autop	an sy	24b. Were autop	sy findings available ipletion of cause of			
	n: The licate r. pag	O		1						2 No	death? 1 ☐ Yes	2□ No			
=	sicier s certif lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☑ No	Hospital:	nt 2 🗆 E B	/Outpatier	nt 3 DOA Oth	er: 4 Nursing Her			☐Other (Specify)				
5	ding Physicien: The lav h. After this certificate has funeral director, page 2	n: T	27. Manner of Seath	28a. Date of Injui (Month, Day		b. Time of		and the second s	28d. Describe h						
5	r Attendir er death. rector: Af by the fur	catic	1 SNatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not leading	on			M 1 🗆	Yes 2 □ No							
2	tal or At s after d al Direct ad in by	Certification:	3 Suicide 6 Could not 1 4 Homicide determined		ury - At home c. (Specify)	, farm, str	eet, factory, office	2	28f. Location (S City or Tow	itreet and i m, State)	Number or Rural	Route Number,			
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 54 hours attendeath.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	To t To ti	Ž	29b. Signature and title of certifier 29d. Discense number 29d. Discense								9d. Date signed (Month, Dey, Year)				
	1		Megle	W 3		D0060478 2					219104				
	0		30. Name and address of person who					CHMDEDIA	ND M	0150	0				
	Sta		AHMAD, AFAQ, M.D.  31. Date filed (Month, Day, Year)		S Signature		ULIE IUZ,	COMBEKLA	עוא פעואע	4100	4				

Registrar

			1 - State Registrar	State of Ma	ıryland	l / Depa <i>Cer</i>	rtment of H tificate of I	lealth a D <i>eath</i>	and M	ental Hyg	iene g. No.	004	05127
	Physici	an	1. Decedent's Name (First, Middle, Las							2. Date of Deat Month January	h Dav	2004	3. Time of Death 6: 42PMM
163 163	/Medic		Woodrow Wilson S  4a. Facility Name (If not institution, give				4b. City, Town, or	Location o		oaridar y		ty of Deeth	0.12111
4	Examin	er	washington Count		1		Hagers				Wash	ingto	n County
	Funeral Director		5. Social Security Number 6. Se		(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under:	Min	8. Date of Birth (Month, Day, Sept 1	3°1915	9. Birthp Cour Ma	olace (State or Foreign rty) ryland
	land		Usuel Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					1	10d. Inside City Limits
	Mary -1 sho	ţo	Maryland Washing	ton	На	.gerst	วพา						¥☐Yes 2☐No
	or 28s	Director	10e. Street and Number	<u> </u>		. 50220	10f. Zip Code			1	0g. Citizen o		ntry?
	ath wi	ral	1106 Kuhn Avenue					740				S.A.	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or itams 23e or 28e-f show supprincing to other traumatic event, i'm Medical Electrical instituted and once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 2 N If Yes, Give Year or Dates:		t	Was Decedent of H f Yes, specify Cuba I □ Yes 2 No	ispanic Origin, Mexican Specify:	gin? (Spe i, Puerto l	ecify Yes or No- Rican, etc.)		ace - Amend lack, White, whi	etc.
ဝို လ	72 ho	Completed	15. Decedent's Ed (Specify only highest gra			(Give	ient's Usuat Occupa	during most	t of workii	ng	16b. Kind of	Business/In	dustry
2	han han	mpje	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. I	00 NOT use retired Chanic	()			Floor	ing C	ompany
0 0	Hygie Hygie other t	CO B	17. Father's Name (First, Middle, Last)			Med	STATILE	18. Mothe	r's Name	(First, Middle, I			anparry
<u>lan</u>	ould be filed within 72 Mental Hygiene. arked other than "nat atic event, the Medici	To Be	Henry Cletus Youn	ker				L	ou Mo	ore			
Maryland 21215-0036	alth and N 27 is ma		19a. Informant's Name/Relationship (7 Allen Weiser/Son	Type, Print)			Box 424						
Baltimore,	Pages 1 and Head Int: If Item Inty or other		20a. Method of Disposition  1 ☐Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify		Cel	metery, crer	sition (Name of natory or other place n Cemeter	cy Ja			20c. Location Hagers		own, State Maryland
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licen	Var	Ü	13		rn Bly	vd. 1	N. Hager	stown		eral Home vland 21742
			23a. Part1. Enter the disease, or comp shock, or heart silure. List only	olications that caused one cause on each lin	the death.	Do not ent	er the mode of dyin	g, such as	cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)  Acute Respiratory failure  Due to (or as a consequence of):										Oriset and Death
P	/Medical Examiner		resulting in Geatily	The state of the s		_	eumonia						
		Jer	Sequentially list conditions if any, leading to immediate	Due to (or as a			Carrottea						
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C			ctive lu	ng di:	sease	9			
8760,	cate be executed physicien and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a		al ref	flux						
Вох 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and cage 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the birth of the bir	2 Fetal o	death 3	Ectopic pregnancy Other (specify)	,				Date of deliver	ery Day Year
ls, P.O.	ires that th signed by d be detacl		Part II. Other significant conditions of	•	ıt not re <i>s</i> ul	ting in the u	nderlying cause give	en in Part I.			pacco use co		he cause of death?
0.00	w requir been si should	eted	Diabetes	METITICUS						816			-
II Rec	The law cate has I	Completed								24a. Was a autops perform	y	prior to co death? 1 \( \sum \text{Yes}	opsy findings available impletion of cause of
Vita Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospitat:			. aClood Oth	er		(Check only on			
Division of Vital Records,	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	tion; To	1 Yes 2 No  27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 2	P/Outpatier 28b. Time of Injury	28c. Injun Worl	4∐ Nu γat	2	me 5 ☐ Reside 28d. Describe ho			(y)
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	To the Hospital o within 24 hours aff To the Funeral Di completely filled in	Medical C		ysician: To the best on niner: On the basis of and manner sta	examination								
	To th To th comp	Me	29b. Signature and titte of certifier	0.0		$\sim$	29c. Licens			1 "	9d. Date sign		
			June	Jun Jun		4	M D0041	1131			Jan. 2	27, 20	04
',	, y		30. Name and address of person who				Print) Hagerstow	n, MD	217	40			
Y	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra			, d		21/				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are ' acidle

State of Maryland / Department of Health and Mental Hygier 2004 05128 For State Registrar 1 Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Andrews February 15, 2004 10:40a<sup>M</sup> Horace /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Chapel Hill Nursing Home Carro11 Randallstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Yrs. 212-30-4963 76 06-21-1927 Director N.Carolina Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. Count r then "neturel", or items 23e or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Md Carroll Mt. Airy 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 4906 Fleming Road 21771 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 252No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after all Hyglene.
other then "neturel", or itel 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Dept. Of Public Works Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17, Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H ient: If item 27 is marked other Be Leola Sellers Odious Andrews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4906 Fleming Road Bessie R. Frye Mt. Airy Md 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2-11-2004 Lorraine Park Woodlawn, Md 22. Name and Address of Facility Loring Byers Funeral Directors 21. Signature of Funeral Service Licenses Important any in 8728 Liberty Road Randallstown, MD 21133-4784 ellner moo337 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HTHEROSCHEROTIC Immediate Cause (Final disease or condition resulting in death) EREBRO VASCUL **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the el 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown been si should l 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has the lirector, page 2 s 2 No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ irector: After this by the funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Direct I in by 4 Homicide within 24 hours a Let Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 285 16 Man Sulle 30. Name and address of person who completed cause of death (Item 23a) (Type) Print) 0 7220 TASNEEM CARHANI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Paul David Ausherman FEBRUARY 5. 1016 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 125 S. BROADWAY BALTIMORE CITY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Oct 2, Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1X M 2□ F 213-42-2176 62 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show to Health and Mental Hyglene.
If item 27 is marked other than "natural, or items 23a or 28a-f show or other traumatic event, it a Nedical Eran it ar must be rediffed at MDBaltimore 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 South Broadway 21231 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No U.T. If Yes, Give unk within 72 hours after 1 Never Married 2 Married unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education unk unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be unk Pages 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If sny injury or \* 4 ☐ Donation 5 🕅 Other (Specify) in state 21. Signature of Eunoral Service Licensee Ronald S. Wade, 22. Name and Address of Facility once. State Anatomy Board Baltimore, MD 21201 ector 655 W. Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Exam Due to (or as a consequence of) Box 68760. Physiclan/Medical as the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year ō Day 5 Other (specify) signed by the a ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by BLADDER CANCER 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 certificate 1 ☐ Yes 2 or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6XOther (Specify) AT SC 1 E 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 2 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Natural Injury 5 | Pending М 1 ☐ Yes 2 ☐ No death. investigation I Director: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospitel within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME FEBRUARY 6, 2004 nun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE MIGH 111 Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 1 9 2004

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygier Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Feb. 4, 2004 Physician 1656 D'Arleane June Brammer /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 01ney Montgomery Montgomery General Hospital 8. Date of Birth (Month, Day, Year) June 14, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M XXXF 75 455-40-4997 1928 Texas Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Itam 27 is marked other then "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County irel", or items 23a or 28a-f show Exemples must be notified at 1X Yes 2 □ No Rockville MD Director Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20855 United States 16516 Killdeer Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 27 is marked other then "natu-traumetic sysnt, if a Mudical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Evelyn Dixon Art Herin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16516 Killdeer Drive, Rockville, MD Herbert L. Brammer/husband 20b. Place of Disposition (Name of cametery, crematory or other place)

Baltimore Crematory at LP 2/8/04 Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2X Cremation 3 ☐ Removal from State Baltimore, MD permit. Page Department of Important: If sny injury or once. 5 ☐ Other (Specify) ` 4 ☐ Donation Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 20852 21. Signature of Funeral Service Licensee 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PNevmonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the attending physicien and thed for use as the burial-transit Lung CANCER The law requires that the death certificate be executed Housed that initiated events resulting in death) Last Due to (or as a consequence of) Obstructive Pulmonary Disease Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes Yes 2 🗆 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 20 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes Certification: To Manner of Death filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After t or Attending 5 Pending 1 Tyes 2 No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February D39190 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. J. Garrett Reilly 18111 Prince Philip Drive, Olney, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar ORIGINAL

YMC	ND J. I	380	DWN JR. For State Registrar		epartment of Health and M Certificate of Death	lental Hygier Reg. I	1€ 2004	05131
3	Physicia /Medic		1. Dependent's Name (First, Middle, Last	BROWN, JR	5	2. Date of Death Month E	Day Year	3. Time of Death 0757 A M
	Examin		4a. Facility Name (If not institution, give UNIVERSITY HOSPI	/	4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
6	Funeral Director		5. Social security Number 3 6. Se	7. Age (Invrs. last birthd	Months Days Hours Min.	8. Date of Birth (Month, Day)	2-10 3/1/2	lage (State or Foreign
	Aaryland I show	or	Usual Residence of Decedent  10a State 10b. County	10c/City, Town/o	r,Location		1	0d. Inside City Limits 1 1 Yes 2 No
	3a or 28a-	ai Direct	10e. Street and Number	Paister St	10f. Zip Code 21/3	10g.	Citizen of What Coun	itry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Ita Madical Examinar must be notified at	by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Y2 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black - White, Specify:	
21215-0036	d within 72 ho giene. ir than "natur ir tha Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementar)/Sedindary (0-12)		ecedent's Usual Occupation livelying of work done during most of work fe, DO NOTILISE religion  The Company of	ing /	ADÜCE	dustry
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, I. e. M.	To Be (	17 Father's Name (First, Middle, Last)	10WN, SI.	onect	e (First) Middle, Maid	1910W	W
	1 and 2 sh Health and em 27 Is m	_	19a Jatornant's Name/Relationship (7)	MAN(GISTER) 3	isposition (Name bi tremalogy provides)	Date 200	g/to/M/	21/21/3
Baltimore,	t. Pa tmer tant: yiury		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funeral Service, License	Della Della State	22, Name and Address of Facility	13-04 F	Alto MC	1. J. Home
Ä	permi Depar Impor any ir	į.	23a. Part 1. Enter the disease, or comp	Summer lications that caused the death. Do not	tenter the mode of dying, such as cardiac	AVE 19	14/60 /NG.	Approximate Interval Between
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	and to neck			Onset and Death
8760,	Examine be executed by sicien and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate the party of the cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)  Due to (or as a consequence of)				
.O. Box 687	ath certific attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death  4 Pregnant at time of death  9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ary Day Year
Ω.	w requires that the debeen signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but not resulting in the	he underlying cause given in Part I.	23e. Did tobacc	ouse contribute to the	ne cause of death?
I Recoi	The lay	Completed				24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of
Vita	Physician: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient ②OER/Outp	Other	h (Check only one)	e 6 □Other (Specif	y)
Division of Vital Records,	or Attending ter death. irector: Afte n by the fune	Certification: T	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  2 14 64  28e. Place of Ciryy At home, from	Ury Work? 1 □ Yes 2 No	28d. Describe how in 28f. Location (Street City or Town, St	t and Number or Rura	TO LO NECL AL ROUTE NUMBER, AL AVENUE
<u> </u>	spits ours nera	edical Ce	29a Conflier 1 Certifying Fits (Check only 2 Medical Exam	raician. To the basis of examination and/	Joseph occurred at the time, data and plans or investigation, in my opinion, death occur	and due to the mass	e(e) and manner as a	totad
	To the Hos within 24 h To the Fur completely	Medi	29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month,	
			•	WI.	O.C.M.E		FEB. 15,	2004
	3		JACK M.	completed cause of death (Item 23a) (T	ype,Print) Penn Street, Baltink	ore, Maryl	and 21201	
1	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Anall &	-		

DHMH 17 Rev 1/2001

ORIGINAL

ern	1- State Unpend Item#	State of Marylan				Mental Hy	gien 20(	16 05132				
Physician (Modica)	Decedent's Name (First, Middle, La			Broato or E		2. Date of De Month Februa	eath Day Ye	3. Time of Death				
/Medical Examiner	4a. Facility Name (If not institution, gin			4b. City, Town, or			4c. County of I	Death				
Funeral Director	213-72-0164	aCl Sex 7. Age (In yrs. 1 □ M 2 X F 46	last birthday) Yrs.	Dunda If Under 1 Year Months Days	LK If Under 24 Hr Hours Min	. (Month, Da	Balt rth ay, Year) 16,1957	imore Birthplace (State or Foreign Country) Marvland				
ite, intally idition Z 1Z 13-0030  s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23e or 28e-1 ehow other traumatic event, if a Medicul Exart or must be notified at To Re Commissed by Erinarai Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltin  10e. Street and Number	ncre	y, Town or Lc	Duncal	k 21222			,				
nours after death	3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	i	Was Decedent of His If Yes, specify Cubar		Specify Yes or No rto Rican, etc.)	0- 14. Race - Black, V	American Indian,				
Idition 2 12 13-00 Ild be filed within 72 ho lental Hygiene. Ked other than "natur ild event, If a Medical		cade completed)  College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of wo		Restau					
should be fill and Mental H s marked oth turnatic even	17. Father's Name (First, Middle, Las  19a. Informant's Name/Relationship	Clarence Smith	19b Mailir		Jacque	eline Ja	ackson	te Zin Codel				
of es 1 and 2 sho of Health and if item 27 is m or other traum	Gloria Meyers /Au 20a. Method of Disposition 1 □ Bunal 2X Cremation 3	20b. P	9636		ue Balti		ryland 212	234				
Dealtimote, permit. Pages 1 an Department of Heal Important; if Item 2 any injury or other once.	4 Donation 5 Other (Speci	ty) Bay	22		s of Facility Ma		napel,P.A.					
Safe be executed hysician and hysician and the burial-transit the burial-transit hysician and the burial-transit hysician and the burial-transit hysician and the burial-burial hybrid h	•	b. Due to (or as a consequence of the consequence o	n. Do not ent  cic Card  uence of):	er the mode of dying	, such as cardia	BAITIMON	U. S. A.  14. Race - American Indian, Black, White, etc.  Specify: White  16b. Kind of Business/Industry  Restaurant  Maiden Sumame)  CKSON  7. City or Town, State, Zip Code)  Yland 21234  20c. Location - City or Town, State  Baltimore, Maryland  uneral Chapel, P.A.  2. Maryland 21214  Approximate Interval Between Onset and Death  23d. Date of delivery  Month Day Year  23d. Date of delivery indings available prior to completion of cause of death?  24b. Were autopsy findings available prior to completion of cause of death?  21 No 3 Probably 4 Junknown  22b. Were autopsy findings available prior to completion of cause of death?  21 No 3 Probably 4 Junknown  22b. Were autopsy findings available prior to completion of cause of death?  22b. Were autopsy findings available prior to completion of cause of death?  22b. Were autopsy findings available prior to completion of cause of death?  22b. Were autopsy findings available prior to completion of cause of death?  22b. Were autopsy findings available prior to completion of cause of death?  22b. Were autopsy findings available prior to completion of cause of death?  22b. Were autopsy findings available prior to completion of cause of death?  22b. Were autopsy findings available prior to completion of cause of death?  22b. Were autopsy findings available prior to completion of cause of death?  22c. No 3 Probably 4 Junknown  23d. Date of delivery  Month Day Year					
The Colids, F.C. box 00/00,  The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  yes 2 No 9  Unknown	23c. If yes, outcome of pregna 1  Live birth 2 Feta 4 Pregnant at time of d	Ideath 3[	Ectopic pregnancy Other (specify)								
w requires that been signed b should be detailed by the bear by th	Part II. Other significant conditions	contributing to death but not resi	ulting in the u	nderlying cause give	n in Part I.			1.				
					76 Pince of De		psy prior deat 2 No 1	r to completion of cause of the				
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	examiner?	28a. Date of Injury (Month, Day Year)	ER/Outpatier  28b. Time of Injury  ome, farm, str	M 28c. Injury Work	r: 4 🗆 Nursing I	dence 6 QOther (	at scene					
he Hospita n 24 hours he Funeral pletely fille		hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the time vestigation, in my op	e, date and plac inion, death occ	e, and due to the curred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)				
To the To the Comp		o completed cause of death (frem	23a) (Tvoe	29c. License O.C.			29d. Date signed (M February					
State Registra	THEN NUNE M. 31. Date filed (Month, Day, Year)	. (/	ture		street,	Baltimor	re, Maryla	nd 21201				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Year TROY 4-45PM BROWN 15 2004 FEB 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Multi Medical Center Baltimore

If Under 1 Year

10f. Zip Code

1 ☐ Yes 2 ☑ No

21226

Days

Months

7. Age (In yrs. last birthday)

62

12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:

Yrs.

Stoney Beach

10c. City, Town or Location

1 M 2 □ F

If Under 24 Hrs.

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

8. Date of Birth (Month, Day, Year)

1941

LISA

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

14. Race - American Indian, Black, White, etc.

White

May 25,

Birthplace (State or Foreign Country)

South Carolina

10d. Inside City Limits 1 ☐ Yes 2√☐ No

Approximate Interval Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

BALTINORE

**Physician** /Medical Examiner

**Funeral** 

5. Social Security Number

413-66-1359

10a. State

Maryland |

10e. Street and Number

Directo

Funeral

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Usuel Residence of Decedent

10b. County

1362 River Bank Court

1 ☐ Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

Anne Arundel

15. Decedent's Education (Specify only highest grade completed)

SHAKUNNALA

31. Dete filed (Month, Day, Year)

Director

pamilt. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mantal Hygiane. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinal must be notified as Physician

Baitimore, Maryland 21215-0020

Examiner physician and the burial-transit Hospital or Attending Physician: The law requires that the death cartificate be axecuted 24 hours after death. this Director: /

/Medical

Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Airline Pilot 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fred S. Jessie Brown Cape ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Tina Rappaport / Daughter 1362 River Bank Court Baltimore, Maryland 21226 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 2-20-04 Tocca, Georgia 4 ☐ Donetion 5 ☐ Other (Specify) Shiloh Baptist Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. Towson, Md. 21204 Cen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBROVASCULAR ACCIDENT disease or condition resulting in death) Due to (or es a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ Be Completed 24a. Was an autopsy performed? 1 Yes 2 ₩No 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Land Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 1. Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 20053150 FEB 1600 2004 rupte MD 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

> GUPTA 32. Registrar's Signature

2004

P.O. Box 68760, Division of Vitai Records, To the Hospital within 24 hours a To the Funeral D completaly filled

DHMH 16 Rev 6/95

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Registrar

State

201-109 BALLIRIVER NECLIRD

Registrar

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State

FEB 1 9 2004

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NUMBER DE

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 State Registrar AMEND ITEM #22 PER FH G828 2/19/04 Gertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Drown FEBRUARY 12, 1chael 2004 9:00A /Medical 4b City Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** UNION MEMORIAL HOSPITAI BALTIMORE CITY
Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 1-13-1956 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 48 Days Hours 15 M 20 F 218-80-4980 m Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "naturel", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 1 Xes 2 □ No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U3A 21218 Alameda by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 BIOCK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) is marked other than 12.14 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LUCKU Willie assia 2 Drown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36th Street MD. 21218 Bait. Gister 1118 bernie E permit. Pages 1 and Department of Health Important: if Item 27 any injury or other tr 2006. Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Zion Dalto 04 4 □ Donation, 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FUN 4905 Circeile 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. FALTO, MD. Immediate Cause (Final **Physician** Deizure DUCKOLOR disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions any cause to immode cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner Physician; The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No o. 9 Unknown been signed by I should be detact Division of Vital Records, P. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coninbute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 □Unknown 24b. Were aulopsy findings available prior to completion of cause of death?

NOTE: NOTE: NOTE: 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 1 24a. Was an page 2 s autopsy 1 Yes 2 No al or Attending Physician; T s after death. al Director: After this certifical ed in by the funeral director. p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 \( \times \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 X Inpatient 1 XYes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 No 910'5 Subject tell investigation MKJUNA Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide unkrown unknown within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certify FEBRUARY 13,2004 O.C.M.E. 1 30. Name and address of person tho completed cause of death (Item 23a) (Type, Print) JACK M. TIMES, M.T. 111 Penn Street, Baltimore, Maryland 21201 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 1 9 2004

Ter State Registrar	of Maryland / Dep	ertificate of E	eaith and iv Death	Re	2004	05136
1. Decedent's Name (First, Middle, Last)				2. Date of Deatl	h Day Year	3. Time of Death
Physician Norman BEDZINI				tehruary	16 2004	0825 AM
4a. Fecifity Name (If not institution, give street and the street	Saltimore	4b. City, Town, or the Baltimore		Date of Righ	4c. County of Deat	N/A
Funeral Director 5. Social Security Number 6. Sex 1 M 2 DF	7. Age (In yrs. last birthda) 73 Yrs.	Months Days	Hours Min.	8. Date of Birth Aug 24,	<b>193</b> 0	nplace (State or Foreign untry) NY
Usuaf Residence of Decedent  10a. State 10b. County	10c. City, Town or I	ocation				10d. Inside City Limits
ik of	BAL	TIMORE				1  Yes 2 □ No
MD N/A  10e. Street and Number  2725 HANSON AVENUE  11. Marital Status  1 Never Married 287 Married 1909 Marr		10f. Zip Code		10	0g. Citizen of What Co	-
2725 HANSON AVENUE	Decedent Ever in U.S. 13	Was Decedent of His	21215	ecify Yes or No-	14. Race - Ame	U.S.A.
1 Never Married 257 Married 157 Ye	es 2 □ No	. Was Decedent of His ff Yes, specify Cubar 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, White	e, etc.
Tolumber of the state of the st	or Dates:	edent's Usual Occupa			16b. Kind of Business/	WHITE
Po College Complete College	ed) (Giv life.	re kind of work done do DO NOT use retired)	luring most of work	king		·
4+  17. Father's Name (First, Middle, Last)	ENGIN		40. Markada Norm	o (Sint Middle A	HOOKER CHE	MICAL CO.
College Colleg	BEDZINER		NANCY	e (First, Middle, M S	ZYTCYN	
V 00 % = = = 0 00 00					City or Town, State, 2	
FAYE BEDZINER / WIFE  20a. Method of Disposition	20b. Place of Dis	position (Name of			RE, MD 2121 20c. Location - City or	
20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from the property of the property	om State cemetery, cr	ematory or other place ISRAEL CEN		5/2004	ROSEDALE,	MD
20a. Method of Disposition  1 A Burial 2 Cremation 3 Removal for  1 Donation 5 Other (Specify)  21. Signature of Fundal Service Licenses		22. Name and Addres	s of Facility SC	L LEVINS	SON & BROS.	, INC.
The state of the s	tec				PIKESVILLE,	MD 21208 Approximate Interval Between
23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final	vel all'.	. / .	111 / 41	1		Interval Between Onset and Death
	to (or as a consequence of):	r (primare	AMIAION	<u>'</u> )		
Examiner  Sequentially list conditions,  decrease along to immediate.  Due	to (or as a consequence of):					
- C cause Enter Underlying						
resulting in death) Last Due	to (or as a consequence of):					
110 the type of type of the type of type of the type of type of type of the type of type o						
DOX OD THE PROPERTY OF THE PRO	outcome of pregnancy	I⊟Ectopic pregnancy			23d. Date of def	•
Division of Vital Records.  Hospital:    A		Other (specify)			Month	Day Year
Division  O COT Attending Physician: The law requires that the ed after conditions contributing to a line of the conditions. The law requires that the ed after this centificate has been signed by the conditions contributing to a line of the conditions. The law requires that the ed after the conditions contributing to a line of the conditions contributing the condi	to death but not resulting in the	underlying cause give	en in Part I.	23e. Did tot	bacco use contribute to	the cause of death?
Cords, w requires should be seen sign should be letted by				1 🗆 Ye	es 2□No 3□Pr	obably 4 Unknown
I Record The law requir cate has been si page 2 should Completed				24a. Was a autops perform	y prior to	topsy findings available completion of cause of
T T T T T T T T T T T T T T T T T T T			26 Place of Dea	1 ☐ Yes 2	2 No 1 □ Yes	2 No
25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1	Inpatient 2□ER/Outpat	ient 3 DOA Othe	ar		ence 6 Other (Spe	cify)
DIVISION  On the first of the month of the continue of the month of th	Month, Day Year) 28b. Time	Work	yat k? Yes 2 □No	28d. Describe ho	ow injury occurred	
27. Manner of Death   1   2   2   2   2   2   2   2   2   2	face of Injury - At home, farm,		163 2 110	28f. Location (SI City or Town	treet and Number or Re	ıral Route Number,
OIVER 10 10 10 10 10 10 10 10 10 10 10 10 10	uilding, etc. (Specify)			City of Town	n, State)	
29a. Certifier Check only 2 Medical Exeminer: On the one)  29b. Signature and title of certifier  29b. Signature and title of certifier	o the best of my knowledge, de he basis of examination and/or manner stated.					
29b. Signature and title of certifier		29c. License	e number	2	9d. Date signed (Mont	h, Dey, Year)
Danies of Mingh	1	KES	000		tebruary 1	, 6004
30. Name and address of person who completed	cause of death (Item 23a) (Typ	e, Print)		1 1	0 11	
27 0 10 2	ai Hospital of Ba	Thinare 240	Ol II Relia	edene thre	Daltimare M	071715

			For State Registrar	State of M	aryland	/ Depa	artment of H tificate of L	lealth an Death	d Mental H	ygien Reg. N	°2004	05137
8	Dhamia		1. Decedent's Name (First, Middle, La						2. Date of 0	Death		3. Time of Death
Card .	Physic Medi		Leif A	rchibald	Cox				Februa		7, 2004	8:20A M
	Examir		4a. Facility Name (If not institution, gir	e street and number)			4b. City, Town, or	Location of D	eath		c. County of Deat	
	```		100 Hutton Street				Gaither			M	lontgome	ry
e	Funeral Director			Sex 7.Ag 11X7M2□F	e (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		Ain. (Month, L	Day, Year	9. Birt Co	hplace (State or Foreign untry)
4.			Usual Residence of Decedent		24	1,0.			July	19,	1979 New	Mexico
	yland		10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City Limits
	a-f s	ctor	Maryland Montgom	ery	Ga	aithei	sburg					1 X Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	untry?
	ath w	rai	100 Hutton Street				20	877		Uni	ted Stat	ces
36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "naturel", or items 23e or 28e-f show unatic event, if a Medical Examinar must be revitibled at	by Funeral	11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1 Yes 2 1 If Yes, Give Year or Dates:		1	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 No	spanic Origin? n, Mexican, Pi Specify:	(Specify Yes or Nuerto Rican, etc.)	10-	14. Race - Amer Black, White Specify: Wh	e, etc.
ğ	2 hou	ted	15. Decedent's E	ducation		16a. Deced	ent's Usual Occupa	ntion		16b k	Kind of Business/I	ndustr.
Maryland 21215-0036	thin 7 B. Metil	Completed	(Specify only highest gri	ade completed) College (1-4or 5		(Give i	kind of work done d O NOT use retired)	uring most of	working	100.7	(III OI DUSIII 1835/1	ridustry
2	od wit	Con	12			None				N	one	
n	be file ital Hy od oth even!	Be	17. Father's Name (First, Middle, Last	)				18. Mother's i	Name (First, Middle	e, Maider	n Sumame)	
$\frac{2}{8}$	should I nd Men marke umatic	ပု	Michael L. Cox						h L. Bre			
Jai			19a. Informant's Name/Relationship (				Address (Street a					
	1 and 2 Health tem 27		Michael L. Cox/Fa	ther	1	00 Hu	tton Stre	eet; Ga				
altimore,	Pages nent of H int: If Ite		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cem	etery, crem	ition (Name of atory or other place		Date		ocation - City or T	own, State
	utmer utant njury		4 □ Donation 5 □ Other (Specif  21. Signature of Funeral Service Lice	··	Loud	on Pa	rk Cremat	tory 02	/23/2004	Ba	ltimore,	MD
E E	permit. Pages Department of Importent: If It any injury or o		(Unthy)	. Dr. VM	1	10	Name and Address mple Trib 40 Rockvi	ille Pi	ke: Rock	vill	emation e, MD 20	Center 852
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. (	Do not ente	r the mode of dying	, such as card	liac or respiratory a	arrest,		Approximate Interval Between
	Physician /Modical		Immediate Cause (Final disease or condition resulting in death)		ebra1							Onset and Death
	/Medical Examiner		Tooding in dodaily	Due to (or as	a consequen	ce of):						
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequen	ce of):						
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	00010 (0. 00	2 00.1000001	00 01).						
<b>-</b>	exection and and ital-tra	Exa	resulting in death) Last	c. Due to (or as a	a consequen	ce of):						
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7	s that med t	by P	Part II. Other significant conditions of	ontributing to death bu	it not resultin	g in the und	derlying cause given	n in Part I.	23e. Did	tobacco L	ise contribute to t	he cause of death?
cords	requires een sign hould be		Respiratory Failur	e					10	Yes 2	XNo 3□Prot	pably 4 Unknown
1)	m 10 01	Completed							24a. Was		24b. Were auto	ppsy findings available
	ate pag	COL							auto perfo	psy ormed? 257 No	prior to co death? 1 \( \subseteq \text{Yes}	mpletion of cause of
71[4	ertific ector,	Be (	25. Was case referred to medical examiner?					26. Place of D	eath (Check only o		10 165	2   140
-	Physic this c	2	1 □ Yes 2 → No	Hospital: 1 ☐ Inpatier		Outpatient	3□ DDA Other	4 Nursing	Home 57 Resi	dence (	6 □Other (Specif	(y)
	ling P	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injun (Month, Day	Year) 28t	o. Time of Injury	28c. Injury a Work?	at	28d. Describe	how injur	y occurred	
NISIOI	death death stor: , the	icat	2 Accident investigation 3 Suicide 6 Could not be					s 2 □No				
2	lor A after Direction by	Certification:	4 Homicide determined	28e. Place of Inju building, etc.	(Specify)	tarm, stree	t, factory, office		28f. Location (	Street and wn, State,	d Number or Rura )	il Route Number,
	spite		29a. Certifier 1 K Certifying Ph	ysician: To the best of	f my knowled	ine death (	occurred at the time	date and pla	on and due to the			
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2   Medical Examone)  29b. Signature and title of certain	iner: On the basis of and manner stat	examination	and/or inve	stigation, in my opir	nion, death oc	curred at the time,	date and	place, and due to	the cause(s)
	F 2 5 8		230. Signiture and the or control	m. 1.	1	1 1	29c. License r	number		29d. Date	e signed (Month,	Day, Year)
	h		an yor	h	1	(1)	D2654	0		Febr	uary 18,	2004
	9		30. Name and address of person who of					10 ~				
	Stat		Carl Schoenberger, 31. Date filed (Month, Day, Year)		Freder's Signatuce	erick	Road; #2	13; Ga:	ithersbur	g, M	D 20877	
	Registra		FEB 1 9 20	32. Ogistra	in S.	Ash						
_			4 444.7			- 7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are I State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Feb 200<sup>Year</sup> 16, 10:20 pm **Physician** Frank Coxon Sr. /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 326 Townsend Road Essex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1√2√M 2□ F Yrs Sept. 22, 1919 Maryland Director 218-09-3709 84 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location r 28a-f show 1 ☐ Yes 2% 📉 🗆 MD Baltimore Essex Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number rai", or iteme 23a or Examiner must be 326 Townsend Road 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours atter c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural," or item any injury or other traumatic event, the Medical Ferr 1 Mayes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 24 No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Western Electric College (1-4or 5+) Elementary/Secondary (0-12) Die Maker 10th 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be John F. Coxon Catherine Kestner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mildred Coxon/wife 326 Townsend Road Baltimore MD 21221
a of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State HollyHillCemetery 2/19/04 Baltimore MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee Baltimore MD onne 300 Mace Ave. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or completations that caused the death-shock, or heart failure. List only one cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ear /Medical Due to (or as a conse quence of). Examiner So uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed Due to (or as a consequence of): physicien Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 X No 3 Probably 4 Unknown 1 ☐ Yes Be Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 20 No 1 Yes or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) examiner' Hospital: Other: Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Leath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 - Homicide Hospitel TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated the e 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier

Registrar

State

ORIGINAL

oaks

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32. Registrar's Signature

30. Name and address of person who completed call of death (Item 23a) (Type, Print)

OHN

DR C

31. Date filed (Month, Day, Year)

		For 1_ State	State of Maryland	/ Departmen	t of Health and N e of Death	Mental Hygien	€2004	05139
• *	w.	Registrar  1 Decedent's Name (First Middle Last)		Certificate	or Death	2. Date of Death	G.	3. Time of Death
Physi- /Med			S EDWA		KK SR.	February	ay 2 Year 2004	07:55AM
Exam	iner	4e. Fecility Name (If not institution, give str	HOSPITAL	Ba. City,	Town, or Location of Death		NA	
Funera Directo	_	213.30 1101	7. Age (In yrs. la	Yrs. If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month, Day, Yea MALCH 10	9. Birthpla 1935 MAC	State or Foreign
ith the Maryland or 28a-f ehow	or	Usual Residence of Decedent  10a. State 10b. County		Town or Location ACTIMUE	2E		100	d. Inside City Limits
with the I	i Direct	10e. Street and Number	RLES St.	10f. Zip		1	Citizen of What County	
II X IX IS-00000 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23e or 28e-f show ont, the Medical Exerning Frust Le notified at	by Funeral Director	001	2. Was Decedent Ever in U.S Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:	3. Was Decedif Yes, special 1 Yes	tent of Hispanic Origin? (S)		14. Rece - America Black, White, et Specify: BL	
within 72 hou and.	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Decedent's Usua (Give kind of wo life. DO NOT us	rk done during most of wor	king	Kind of Business/Indu	- 1
Identify A.1.C. and be fitted within fental Hygiene. rked other than tic event, the M.	To Be Co	17. Father's Name (First, Middle, Last)  JESSIE CLA	ARK SR.			ne (First, Middle, Maide TRAH	en Sumame)	
OTE, MAI VIGILIU Z.I.Z.I.D-0030 es 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. I flem 27 is marked other than "natural", or Items 23a or 28a-f ehot r other traumatic event, the Medical Expansion must be notified at		19a. Informant's Name/Relationship (Type)  JAMIES E. CLARK  20a. Method of Disposition  1 Medial 2 Cremation 3 Re	IR. /SON 206. PI	1500 Sou	(Street and Number or Ru THVIEW TOK ne of ther place)	OATE AST.	301 DXON Location - City or Tow	HLL MD 2019
Pag nent ant: f		*4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	CKO	WASVILLE O	CEMETERY 2.  Id Address of Facility V	18.04 CH	REENE FUL	MERTE HOME
Demit permit Depart Import any Inju	once	Vauxe	Lune	4905	YORK ROAZ	BACTIMO	RE, MO:	21212
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death certific e attending p	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic p			23d. Date of deliver Month	y Day Year
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The lay ate has page 2	Completed	TOTAL COLOR	<u> </u>			24a. Was an autopsy performed	death?	sy findings available pletion of cause of
r VITA ysician: ys certific director,	o Be	25. Was case referred to medical examiner?	ospital: 1   Inpatient 2	ER/Outpatient 3 🖳 💩	Other	ath (Check only one)	6 □Other (Specify)	)
P P P P P P P P P P P P P P P P P P P	끝	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1  Yes 2 No	28d. Describe how in	jury occurred	
UNISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factor	y, office	28f. Location (Street City or Town, St.	and Number or Rural ate)	Route Number,
Hospit 24 hours Funera tely fille	ledical (	29a. Certifier 1 Certifying Phys. (Check only one)	ician: To the best of my knower: On the basis of examinat and manner stated.					
To the within ? To the comple	Med	29b. Signature and title of certifier		29	c. License number		Date signed (Month, E	
· (		30. Name and add/ess of person who col	inpleted cause of death (Item	23a) (Type, Print)	7 46009	Fo altimore	chruary	17,2004
`	State	Dale Barnes  31. Date filed (Month, Day, Year)	9 32. Registrar's Signa	LU Ravel	161Va, 150	ultimore	MD 21	239
A	State istrar	FEB 1 9 2004	Percent. 18	Acres 6				

Patient Known as George Cunzeman Sr. Baltimore, Maryland 21215-0036

			For	Type or Print in State of Maryla	nd / Dep	artment of H	ealth and I	-		004	05140	
	Physici		1 - State Registrar  1. Decedent's Name (First, Middle, Last, GEORGE H. CUN		Ce	rtificate of L	Jeath	2. Date of D Month	Day	Year	3. Time of Death	
	/Medic Examin Funeral		4a. Facility Name (If not institution, give SIVAL HUSPITAL) 5. Social Security Number 6. Second	of Baltim	OVE s. last birthday,	Balfine It Under 1 Year	If Under 24 Hrs.	8. Date of B	N/A	y of Death	ce (State or Foreign	
	Director		218-18-0055 Usual Residence of Decedent	<sup>1M 2□F</sup> 78	Yrs.	Months Days	Hours Min.	6/17/1	9ay, Year) 1925	MARYI	LAND	
	e Marylan 8e-f show	ctor	MD BALTIM		WOODLA	WN					. Inside City Limits 1 ☐ Yes 2 ☐ No	
	ith th	Dire	10e. Street and Number			10f, Zip Code			10g. Citizen of		7	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene importent: If item 27 is marked other then "natural; or items 23a or 28e-f show mith jointy or other traumatic avent, I'm Medical Examinar must be notified at DDCs.	by Funeral Director	6811 CAMPFIELD RC  11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 15 Yes 2 No		21207 Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☐ No		pecify Yes or N o Rican, etc.)		SA ce - American ck, White, etc	<b>.</b>	
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Mar	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (T)								100)	
Baltimore, I	Pages 1 and 2 nent of Health out: If Item 27 iry or other tru		GEORGE H. CUNZEMAN  20a. Method of Disposition  1 Remail 2 Cremation 3 F  4 Donation 5 Other (Specify)	20b. Removal from State	Place of Disp cemetery, cre	S SCHERER osition (Name of matory or other plac S LUTH CH	е)	BALTIMO Date 21/04	20c. Location SWEETA		ı, State	
Baltir	permit. Pag Department Importent: I any injury o once.		21. Signature of Funeral Service Licens	· Huye	/ 2	2. Name and Addres 3521 LOCH	ss of Facility T RAVEN BL	HE JOHN VD. TO	ISON FUNI DWSON, MI	ERAL HO	OME, P.A. 86	
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	Str	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	Sime H	espital	or T	altim	ure		

DHMH 17 Rev 1/2001

State

Registrar

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32. Registrar's Signature

FEB 1 9 2004

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	٦.	that hed by deta	y Ph	Part II. Other significant conditions co	ntributing to death	but not res	sulting in the u	nderlying o	ause giv	en in Part	1.	23e. Did	tobacco	use contribute	to the	cause of	death?
	rds	w requires that been signed I should be det	d b	EMPH"	YSEMA							1 💢	Yes 2	2 □ No 3 □	Probab	oly 4 □	]Unknown
	၀	s bee	plet									24a. Was		24b. Were	autops	y findings	available
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	× ×	Physic this co	2	1 ☐ Yes 25 No	Hospital: 1 ☐ Inpa		ER/Outpatier			4 🗆 14				6 ☐Other (S	pecify)		
	ū	ing P	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time of Injury	f M	8c. Injury Work	/at k? Yes 2□		28d. Describe	how inju	ary occurred			
	Sic	ttand death stor: ,	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of I	niury - At h	ome farm etr			195 2		28f. Location /	Street a	nd Number or	Rural F	Route Nu	mber.
	Division of Vital Records, P.O. Box	after Direct	Certification:	4 Homicide determined		etc. (Specif		eet, lactor	y, omce			City or To					
ړ	_	Hospital 24 hours a Funeral I tely filled	aC	29a. Certifier 1 Gertifying Phy													
1		To the Hospital or Attanding F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical	(Check only 2 Medical Exam	iner: On the basis and manner:		ation and/or in	vestigation	, in my o	pinion, dea	ath occurre	ed at the time,					(s)
		To the comp	Σ	29b. Signature and title of certifier	`					number	-			ate signed (Mo			
	7	^			vaela		Mi	)	DI	477	30		00	C-18	- 0	124	
		•		30. Name and address of person who c		death (Iter	m 23a) (Type,	Print)	= D r	1011	E.	SINTE	211	L-18	-21	231	
		, Ct-	ate	31. Date filed (Month, Day, Year)	11 -	trar's Signa	aturo			و تحسا		-0110			-,		
		Regist		FFR 1 9 2004	Gener	00	5 1	bork	2								

State of Maryland / Department of Health and Mental Hygiene 2004 05142 Stete Registral MEND ITEM #26 PER OHY G828 2/19/04 Dertificate of Death 3. Time of Dead 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8:00P M Concetta T. Campagna February 10 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Perry Hall

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | 4508 Cottington Road Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖸 F 214-18-6634 85 Yrs. 18,1918 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or itema 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinal multiple particles. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☑ No Maryland Baltimore Baltimore Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1112 McAdoo Avenue 21207 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status t □Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3√ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be ျှ Salavatore Glorioso Unknown Brocotta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4508 Cottington Road Baltimore, MMaryland 21236 Anthony Campagna (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 2-14-2004 Baltimore, Maryland 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228 21. Signature of Funeral Service Ligensee Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician unp Cencer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician ar s the burial-ti Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical ast attending p for use as IE FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed' 1 Yes 2 No 1 🗌 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be SON's Other: 4 Nursing Home Schemence 6 Pather (Specify) HOME. 1 ☐ Inpatient 2 ☐ ER/Outpatient ပ 1 Yes 2 No 3 DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Alter 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours of To the Funeral 153 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D-40521 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospitel DR. OURNE 31. Date filed (Month, Day, Year) 32. Registras Signature State FEB 1 9 2004 > Registrar

			1 - For State Registrar	State of Maryla	nd / Depa	artment		Mental Hyg	iene 200	4 05143
	Physici /Medic	al	Decedent's Name (First, Middle, Learnes Thomas	Calk		,		2. Date of Death Month February	Day Yea	
	Examir	er	4a. Fecility Name (If not institution, g	ive street and number)		4b. City, 1	Town, or Location of Dea		4c. County of De	
	Fundada.	- 12	344 Greenlow RD  5. Sociel Security Number 6.	Sex 7. Age (In yrs	a. last birthday)	If Under	Catonsvi 1 Year   If Under 24 Hr			imore
	Funeral Director		216_03_1834 Usual Residence of Decedent	1 <b>™</b> M 2□F 88	Yrs.	Months	Days Hours Mir		Yeer) 1915	irthplace (State or Foreign Country) MD
	arylanc show	١	10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23e or 28e-f show svent, in medical Examinar must be notified at	Director	MD Baltin	nore	C	atons		10	g. Citizen of What (	1 ☐ Yes 2 🕱 No
	h with	0	344 Greenlow RD				21228	'	USA	outiney :
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decede	ent of Hispanic Origin? ( fy Cuban, Mexican, Pue	Specify Yes or No-	14. Race - An	nerican Indian,
36	hours after tural', or ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2√2 No If Yes, Give	1	1 ☐ Yes 2		no ricen, etc.)	Black, Wh	ite, etc.
Ö	hours tural	q pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's I	Year or Dates:	162 Door	dont's Hausi	Occupation			White
Maryland 21215-0036	n nat	Completed	(Specify only highest g	rade completed)	(Give	kind of work DO NOT use	k done during most of wo e retired)	orking	6b. Kind of Busines Kimbel—Ty	,
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Pu	be filed tal Hygid d other svent, t	Bec	17. Father's Name (First, Middle, Las	t)			18. Mother's Na	ime (First, Middle, M		
yla	2 should be and Mental is marked or raumatic sv	2	Lloyd Calk				Anna	May Poisa	a.1	
Jar	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship				(Street and Number or F		•	Zip Code)
a)	of Health of Health litem 27 I		Ann Marie Gardne  20a. Method of Disposition		344 Place of Dispo			ltimore, N		- T C1-1-
Baltimore,	permit. Pages: Department of H Important: If ite any injury or ot		1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cemetery, crer	natory or oth	her place)		Oc. Location - City o	
Ħ	artme ortan injur	-	21. Signature of Funeral Service Lie	110	ew Cath	. Name and	Address of Facility	17/2004	Baltimore	
B	Depa Impo any ii		VKu lill	Lul)	S	terlin	ng Ashton S mondson Ave	chwab Fune	eral Home	Inc.
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of Vital Records, P	8 6 8	d by PI	Part II. Other significant conditions	contributing to death but not re-	sutting in the ur	nderlying cau	use given in Part I.	23e. Did toba	. /	robably 4 Unknown
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H.	The I	E O						autopsy perform 1 ☐ Yes 2	prior to death? No 1 ☐ Ye	completion of cause of
/ita	ortifica ctor.	Bec	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one)		22110
¥ \	Physician: this certificanal director,	2	1 □ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatien			Home 5 Residen	ce 6 □Other (Spe	ecify)
ion	ttending P death. ctor: After I the funera	atlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	c. Injury at Work? 1  Yes 2  No	28d. Describe how	injury occurred	
Division	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not l		nome, farm, stre	et, factory,	office	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	• Hospi 24 hour • Funer letely fill	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knimer: On the basis of examinating and manner stated.	owledge, death ation and/or inv	occurred at estigation, in	the time, date and place n my opinion, death occu	e, and due to the cau urred at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the To the Complex	₩	29b. Signature and Little of certifier			29c.	License number	290	d. Date signed (Mon	th, Dey, Year)
)	1		1/1/1	Sutherness		T	2005982	31	2/16	104
	C		30. Name and address of person who	completed cause of death (Itel	m 23a) (Type, I	Print)	H 601	N. CAP	OI INCE	104 ST 21287
	Sta Registr		31. Date filed (Month, Day, Year)	9 2004 Registrati's Sign	ature /	dose	and the same of th	10 ,011/0	UIV Z	01

DHMH 17 Rev 1/2001

Call. Charles J.

		1 - For State Registrar	State of Marylan	d / Depa	artment of F	lealth and Death	F	Reg. No. ZUL	_
Physici		Decedent's Name (First, Middle, Last)     David Coder					2. Date of Dea Month		3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Dea		4c. County of	
Funeral Director		North Arunde1 Gen 5. Social Security Number 6. Sex 213-68-2763			Glen Bi If Under 1 Year Months Days			, Yeer)	arundel . Birthplace (Stete or Foreign Country) hio
and w		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
Marylan -f show	Ö	MD Baltimore		(	Catonsvil	1۵			1 ☐ Yes 2 ☐ No
r 28a	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
th with	a D	ll4 Fairfield Dri	ve		21	228		U.S.A	
itied within 72 hours after death with the Maryland Hygiene. Hygiene. The "natural", or Items 23e or 28e-f show ent, the Marical Exam not must be mailified.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- ito Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occup	during most of w	orking	16b. Kind of Busin	ness/Industry
within 100 miles	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	•		17.a.t. a.s.	C1
Hygie ther int.		17. Father's Name (First, Middle, Last)	2		Purchase		ame (First, Middle,		Supply
d be annual cod o	To Be	John L. Coder				Mildred		,	
shoul nd M	F	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	ng Address (Street		I II uax Rural Route Numbe	r, City or Town, St	ate, Zip Code)
alth a		Margaret F. Drape	r-Coder/Wife	114	Fairfield	Drive	Catonsvi	11e, MD 2	21228
item item		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of matory or other place		Date	20c. Location - Ci	ty or Town, State
Page nent c		1 ☐ Burial 2 ☑ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		e/Washing	1	17/2004	Laurel,	MD
permit. Pages 1 and 2 should be filed within Department of Health and Manhall Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Manhall page.		21. Signature of Funeral Service License		22	2. Name and Addre	ss of Facility Wi	itzke Fun	eral Home	e of Catons-
205 2 2		Demank	between						lle, MD 21228
Physician		23a. Part1. Enter the disease, or complia shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	ar		ig, such as cardia	ac or respiratory ari	rest,	Approximate Interval Between Onset and Death
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be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
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ate by thysic the but	lcal								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brouss after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3[	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	,
that the de	Ph	Part II. Other significant conditions con	tributing to death but not rest	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ate to the cause of death?
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s been s	Completed						24a. Was a	ın 24b. We	re autopsy findings available
The lav	E O						autop: perfor 1 🗆 Yes	med2 dea	r to completion of cause of th? Yes 2□ No
ysician: The is certificate his director, page	ø	25. Was case referred to medical				26. Place of De	ath (Check only or		20110
Physic Physic this ce at direc	To B	examiner? 1 \( \text{Yes}  2 \text{PNo} \)	ospital: 1 🗌 Inpatient 2 🕼	ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing	Home 5 ☐ Resid	ence 6 Other	(Specify)
ding Phy h. After thi		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	f 28c. Injur Wor		28d. Describe h	ow injury occurred	
tendi feath. for: A	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No			
To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	′)			City or Tow	n, State)	or Rural Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Madical Examinate)	icien: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, deatl tion and/or in	h occurred at the tir vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the courred at the time, o	ause(s) and mann late and place, and	er as stated. I due to the cause(s)
o the rithin of o the omple	Mec	29b. Signature and title of certifier	gira matition stateu.		29c. Licens	e number	2	9d. Date signed (/	Month, Day, Year)
⊢ 3 ⊢ ŏ		1 Granes	Jan		D 6	650	l l	/-	
13		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)			2/15/ Baeto/	
\		George D.	Lawren		Stilly	he the	sp. h	Baelol	u
Sta		31. Date filed (Month, Day, Year)	32. Register's Signa	ture 1	And .		, ,		

State of Maryland / Department of Health and Mental Hygiene 2004 05145

	Certificate of Death	Reg. No.	04 0514
Dhuaisia	1. Decedent's Name (First, Middle, Last)	2. Dete of Deeth Month Dev	3. Time of Death
Physiciar /Medica	01 1 17 1 0 1	Month Dey February 15, 20	Year 004 7:45 A.
Examine	An English bloom of the analysis of the standard of the standa	, or Location of Deeth 4c. County	
	Augsburg Lutheran Home Baltim	ore Balt	imore
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24		Birthplace (State or Foreig Country)
Director	219-30-1830   10x M 2 F   70   Yrs.   Months Days Hours	Feb. 18, 1933	Maryland
p ,	Usuel Residence of Decedent		
aryta Bhov	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limi
W Tal	Maryland Baltimore Baltimore		1 □ Yes 2](1)
n 72 hours after death with the Manyland "netural", or items 23s or 28s-f show solical Examiner must be notified at lated hy Finneral Director	10e. Street end Number 10f. Zip Code	10g. Citizen of V	What Country?
th with	8100 Rossville Blvd. 21236	United	States
aep at 5	11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispenic Origin Armed Forces? 15. Was Decedent of Hispenic Origin If Yes, specify Cuban, Mexican P	? (Specify Yes or No- 14 Bac	e - American Indian,
aftar ar		uerto Rican, etc.) Blac	ck, White, etc.
ours Erro	3 ☐ Widowed 4 ☐ Divorced If Yes, Give ☐ 1953 to 1☐ Yes 2 ☐ No Specify: Year or Dates: 1955	Specify	white
ed within 72 hours a ygiene.  Nor than "natural", c.  It, the Medical Exact.	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Bu	usiness/Industry
- 2	(Specify only highest grade completed)  (Give kind of work done during most of life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	working	
be filed within tral Hygiene. d other than "event, tra Mar	12 -0- Installation Technic	cian Heatin	g & Air Condi
EIPE A		Name (First, Middle, Maiden Sumam	
should be nd Mental marked o imatic eve		Δ	Sonn
E B E E	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of		
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- £ 5 5	20e. Method of Disposition 20b. Place of Disposition (Neme of		21206 City or Town, State
o o	1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	Feb 21	Ony or Town, State
parmit. Peg Department Important: i any injury o gitce.	4□Donation 5□Other (Specify) Dulaney Valley Memorial Gdns	. 2004   Timoni	um, Maryland
ny in	21. Signature of Funeral Service Licensee  Brian T.   22. Name and Address of Facility Chisholm Funeral	Home Services of	Dulaney Vall
0 C) ≥ 4 O	200 E. Padonia Ro	oad, Timonium, MD	21093
	23e. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.	diac or respiratory arrest,	Approximate
hysician	Shook, of real failure. List only one cause on each line.		Interval Between Onset and Death
/Medical	Immediate Cause (Final		
Examiner	disease or condition resulting in death) e.		1 fears
<u> </u>	Due to (or es a consequence of):		
Serrincate be executed ding physician and se as the bural-transit	b		
exec n an ial-tr	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying		
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s the	resulting in death) Last  Due to (or as e consequence of):		1
ding se as	d		
etter for u			
Vegures that the open of been signed by the etten should be detached for u letted by Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use con	tribute to the cause of dea
P detay		1 🗆 Yes 2 🗆 No	3 Probably 45 Unknown
requiras that the clearn yean signed by the ette ihould be detached for eted by Physicia		_	
een houlk		24a. Wes an autopsy performed?	24b. Were autopsy finding available prior to
as b		-	completion of cause of death?
pete has been s' pege 2 should		TLIYUS ZXNO	1 ☐ Yes 2 ☐ No
ertific actor, Be C	25. Was case referred to medical 26. Place of 1	Death (Check only one)	
his cell direct	Hospital:	g Home 5 ☐ Residence 6 ☐ Othe	r (Specify)
ere l	27. Manner of Deeth 28e. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how injury occurre	
to a far.	1 Matural 5 Pending (Month, Dey Year) Injury Work? 2 Accident investigation M 1 Yes 2 No		
rs aftar deeth.  al Director: After this certification: To Be ( Certification: To Be (	3 Suicide 6 Could not be	28f. Location (Street and Number	or or Rural Route Number
olre Dire	4 ☐ Homicide building, etc. (Specify)	City or Town, Stete)	TOT Harar House Harriber,
Surse O	29a. Certifier 157 Certifying Physician: To the best of my knowledge death occurred at the time date and old	1	
In 24 hour he Funer pletely fill edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of	ace, and due to the cause(s) and man ocurred at the time, date and place, as	ner as stated. nd due to the cause(s)
within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2  Medical Certification: To Be Comp	and manner stated.		
\$ P 8	29b. Signature and title of certifier 29c. License number		(Month, Day, Year)
1.7	737	573 Februs	4 1615001
211	30. Name and eddress of person who amplified cause of death (Item 23e) (Type, Print)		1
9	JEF Zibell MD 25 Main St. Reistosten N	ID 21136	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Registrar	1 0 2004 Keeters & sports		

DHMH 16 Rev 6/95

S	ni crary	9		State of Marylar a,Part II,27,28				Mental Hyg		04 1	05146
	Physicia /Medic	al .	Decedent's Name (First, Middle, Last)     Joseph Michael      Facility Name (If not institution, give s			4b. City, Town, or	Location of Dea	2. Date of Deat Month Februar	Day \	Year 04	Time of Deam
VIV.	Funeral	C.	3404 East Baltime 5. Social Security Number 6. Sex	ore Street	s. last birthday) Yrs.		lf Under 24 Hrs Hours Min	S. 8. Date of Birth	Year) S	9. Birthplace ( Country) Maryla	(State or Foreign
)	Director	J.	Usual Residence of Decedent   10a. State	10c. C	ity, Town or Lo	ocation altimore	9	0-9-1	) 12   1	10d. In	nside City Limits
	h with the M 23a or 28a-f	al Directo	10e. Street and Number 3404 E. Baltimo	ore St.			1224		0g. Citizen of Wr USA		
396	be filed within 72 hours after death with the Maryland tal Hygiene.  do other than "natural", or itama 23a or 28a-f show event, the Modical Examinat miss be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Amarried  3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☑ No		Specify Yes or No- rto Rican, etc.)	Black,	- American In- , White, etc. white	
21215-0036	within 72 hou ane. than "nature ite Modical E	ompleted	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired of Bali	during most of w d)	orking	16b. Kind of Bus Domest	·	-
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic evant, Itie M.	To Be Co	12th 17. Father's Name (First, Middle, Last) Herman Craig	22.11			Genevi	ame (First, Middle, I	Z		41
	ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic		19a. Informant's Name/Relationship ( <i>Typ</i> ) <b>Tina M. Oakes</b> 20a. Method of Disposition	20ь.	340	-	ltimore		1timore	e, MD City or Town, S	21224 State
Baltimore,	permit. Pages 1 and is Department of Health Important: If Item 27 any injury or other tr once.		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Gi	reenmo	unt 2. Name and Addre	ss of Facility	Joseph N g St.,Ba	Baltimo Zann	ino J	r. FH
	Physician		23a. Part1. Enter the disease, or complishock, or hear failure. List only or Immediate Cause (Final disease or condition	4//	ath. Do not en	ter the mode of dyir	ng, such as cardi			App	proximate erval Between set and Death
3760	/Medical Examiner cian and portial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of	equence of):						
O. Box 68	Attanding Physician: The law requires that the death certificate tordeath.  In death.  actor: After this certificate has been signed by the attending physic  by the funeral director, page 2 should be detached for use as the to	Completed by Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	etal death 3	□Ectopic pregnanc □ Other (specify)	у		23d. Date Mont	of delivery th Day	y Year
rds, P.O.	quires that the same of the sa	ed by Ph	Part II. Other significent conditions con Cocaine and Narcotic		esulting in the	underlying cause gn	ven in Part I.		bacco use contri es 2 □ No		1 .
al Reco	sician: The law requ certilicate has been rector, page 2 shouli	Complet							sy pr med? de 2□No 1	vere autopsy frior to complete eath?	findings available ation of cause of
Division of Vital Records,	ding Physiciar h. After this certif funeral directo	tion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	lospital: 1   Inpatient 2  28a. Date of Injury  fourthanth, Day Year)	ER/Outpatie	of 28c. Inju	her: 4 🗆 Nursing			ed	
Divisi	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe found at hom	t home, farm, s ecify)				treet and Numbe		timore, MD
	To the Hospital or A within 24 hours after To the Funaral Dirac completely filled in by	Medical (	29a. Certifier (Check only one) 1 Certifying Phy one) 2 Medical Exami	sicien: To the best of my kiner: On the basis of examand manner stated.	knowledge, dea ination and/or	nvestigation, in my	opinion, death oc	courred at the time, o	date and place, a	ind due to the	cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Poller.	w	OCME	se number		29d. Date signed February		
			30-Name and address of person who c	ompleted cause of death (I	tem 23a) (Type	9, Print) 111 E	Penn Str	eet, Balt	imore, M	1arylar	nd 21201
*	S: Regis	ate trar	31. Date filed (Month, Day, Year)	32. Registrar's Sig		porks					

DHMH 17 Rev 1/2001

ORIGINAL

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cr	n		Amend Item#1  - State Unpend Item#23	State of Ma,27,Per M	aryland E <b>, G82</b> 9	d / Depa <b>,3/16</b> 60	artment <b>Mific</b> ate	of He	alth and N eath		giene Reg. No.	200	4 05	14
		4get	Decedent's Name (First, Middle, Last)							2. Date of De.	ath Day	Yeer	3. Time o	of Death
4	Physicia /Medic		Willie K. DuBose,	Jr. Will:	ie Keit	h DuBos	<b>e</b>			Februar			1:30	A M
	Examin		4a. Fecility Name (If not institution, give s	treet and number	)				ocation of Death		4c.	County of Dea	th	
		ž.	Sinai Hospital				Bal If Under 1	timo	CC If Under 24 Hrs.	10 D (D)		N/A	theless (Ctots	
(1)	Funeral Director		220-76-1606	M 2 F		O Yrs.			Hours Min.	8. Date of Birt (Month, De 08/30/	y, Year) 63	9. Bi	thplace (State ountry) MD	
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside 0	City Limits
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	with 3a or		5502 Jonquil Avenu	e			212	15			US	SA		
	death ms 2;	by Funeral Director		12. Was Deceden	Ever in U.S	S. 13.	Was Decede	nt of Hisp	anic Origin? (Sp	pecify Yes or No Rican, etc.)	- 1	14. Race - Am Black, Whi		
9	or Ite	F	1 X Never Married 2 ☐ Marned	Armed Forces 1  Yes 2  If Yes, Give			illes, specii 1⊟ Yes 2l		Specify:	o i tiodii, oto.,	1	Specify: A		
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5-0	72 h natu	etec	15. Decedent's Edu (Specify only highest grad	cation e com <i>pleted)</i>		16a. Deced (Give	dent's Usual kind of work	done dui	on ring most of worl	king	16b. Kir	nd of Business	/Industry	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28a-f ahow he Madical Examirar must be multied at	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		nager	1011100)			Food	l Servi	ce	
2	iled v Hygie ther t nt, m	ပိ	12 17. Father's Name (First, Middle, Last)	00				1	8. Mother's Nam	ne (First, Middle.	, Maiden	Sumame)		
Maryland	d be intal	o Be	Willie DuBose						Dorothy	M DuBos	se			
<u></u>	should nd Me mark	ပ	19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailir	ng Address (			ral Route Numbe		Town, State,	Zip Code)	
Z Z	nd 2 s lith ar 27 ls r treu		Dorothy M DuBose	(mother	)	5502	Jonqu	iil A	ve. Ba	ltimore,	, MD	21215		
ē	s 1 ar f Hea item othe		20a. Method of Disposition		20b. PI	lace of Dispo	sition (Name	of er place)		Date	20c. Lo	cation - City o	Town, State	
Ę	Page ient o nt; tf ry or		1 XBurial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)		3	g Memo			02/2	1/04	Randa	allstow	n, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mential Hygiene. Importent; tr item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other treumatic avant, the Medical Experiment must be notified at 200ce.		21. Signature of Funeral Service Licens	16/-		1	Name and		Wy	lie Fund t, Bal	eral timom	Home,	PA 21217	
a de	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	cause on each Sarcoido Due to (or a	sis		ter the mode	of dying,	such as cardiac	or respiratory a	rrest,		Approxima Interval Be Onset and	etween
	ecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a										
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Vital Records,	The law requires that the te has been signed by the age 2 should be detached.	Completed									psy ormed?	prior to death?	utopsy finding completion of	s available cause of
all			25. Was case referred to medical						OS Blace of Dec	1 ☐ Yes		1 ☐ Ye	s 2 No	
Ξ	Physician: r this certific ral director,	To Be	evaminer?	Hospital:	tient 2	ER/Outpatie	nt 3 DO/			ome 5 Resi		5 □Other (Sp.	ecify)	
on of	ng After	ion: T	27. Manner of Death 1 ▲ Natural 5 □ Pending	28a. Date of In (Month, L		28b. Time of Injury		c. Injury a Work?		28d. Describe				_
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	To the To the comple	Mec	29b. Signature and title of certifier	and mained			29c.	License	number		29d. Dat	e signed (Mor	th, Day, Year)	
	7 × 7 8		VII 1 11	11 1				0	.C.M.E.		Feb	ruary 1	L7, 200	4
			30. Name and address of person who of		death (Item	123a) (Type			01	Paltimo			3 0400	.1

State Registrar

Theodore King M.D.
31. Date filed (Month, Day, Year)
FEB 1 9 2004

32. Registrar's Signature

			1 - For Registrer	State of M	larylaı		artment o			and M	lental l		ne No20	04	05	148
	Dharia		1. Decedent's Name (First, Middle, Last	)							2. Date of				3. Time o	f Death
	Physici /Medi		Margaret S.	Fleming							Feb.	16,	2004	Year	5:55	A <sup>M</sup>
):	Examir		4a. Fecility Name (If not institution, give		)		4b. City, To						4c. County			
			Future Care Cher  5. Social Security Number 6. Se		. //	7	If Under 1		terst				Ва	ltim		
	Funeral Director			х ]м 2 <b>К</b> ]F	ge (in yrs 92	. last birthday) Yrs.		Days	Hours	Min.	8. Date of (Month)	Dey, Y	1911	9. Birth	place (State ntry) y land	or Foreign
	p ,		Usuel Residence of Decedent	<del>-</del>												
	sho	5	10a. State 10b. County		100.0	ity, Town or Lo									10d. Inside C	ity Limits 2X No
	28a-i	Director	Md. Balti  10e. Street and Number	more			Timon			-		100	. Citizen of V	Mhat Cou		
	3a or	ā	P.O. Box 4406				2109		406			.09	US		y.	
	death	nera	11. Marital Status	12. Was Deceden Armed Forces	Ever in U	J.S. 13. V	Was Decedent f Yes, specify			gin? (Spe	cify Yes or	No-	14. Rac	e - Ameri	cen Indian,	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other then "natural", or Items 23s or 28s-f show or other traumatic event, Its Muzikes Examinar must be notified at	Completed by Funeral	1 Never Married 2 Married	1 ☐ Yes 2X If Yes, Give	<b>M</b> o		Yes 20		Specify:	, ruerto	riceri, etc.,		Specify	ck, White,		
Ö	hour fural	ed p	3XXWidowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	-	16a Decer	ient's Usual C	)ccupat	tion			16	b. Kind of Bu	WH	i te	
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ē,	f Hea ftem		20a. Method of Disposition			Place of Dispos cemetery, cren	sition (Name	of			ate	-	c. Location -			
altimore,	Page nent c int: If iry or		1  Burial 2  Cremation 3  P  '4 Donation 5  Other (Specify)		1	eland !			1	/20/	04	Ba	ltimor	e. M	arylan	ıd
a	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Licens	ee/	/		. Name and A					WSO	n Fune	ral	Home,	Inc.
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	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, or heart failure. List entry or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Inde	Due to (or as	2h a consec	eimer quence ol):					respirator	y arrest			Approximat Interval Bet Onset and I	ween
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Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	1				-		of Death	(Check on	y one)				
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0	ding th. : After funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year)	Injury	200. M	Injury a Work?	u s 2⊟N		ad. Descrit	e now i	njury occurre	a a		
UIVISION	al or Attending : after death. I Director: After d in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At h tc. <i>(Specii</i>	ome, farm, stre fy)				_	81. Location City or			r or Rura	Route Num	ber,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	sician: To the best ner: On the basis of and manner st	a granting	owledge, death ation and/or inv	occurred at the estigation, in	ne time my opir	, date and nion, death	place, a	nd due to the	ne caus e, date	e(s) and mar and place, a	nner as st nd due to	ated. the cause(s)	
	To the Ho within 24 I To the Fu completely	ž	29b. Signature and title of certifier	<u> </u>			29c. Li						Date signed			
	2		Naven & fa				D	00	58	67	6	Fe	a-uary	116	, 200	4
	σ		30. Name and address of person who co Karen L. Babi	++ M.B	> 2	5 Mai	Print)	02+								
	Sta Registra	- 3	31. Date filed (Month, Day (Bar) 1 9	2004 <sup>32. Region</sup>	ar's Signa	ature /	frank.	A.		-						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Jacible State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Gloria Fromm 5:55 Am February /Medical 17 2004 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Stella Maris Hospice at Mercy Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1□ M 2□XF Hours Days 542-20-3772 78 Director Vrs Ĩ'926 Oregón Usual Residence of Decedent filed within 72 hours efter death with the Marylend 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1X Yes 2 □ No MD N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 Upland Road Apt G5 21210 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 "naturel", or 1 ☐ Yes 2 X No Specify: Š 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementery/Secondary (0-12) Homemaker s 1 end 2 should be filed v f Health end Mentel Hygle tam 27 is marked other ti Own Home 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Carl David Josi Marie Depardeux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Katy Shaffer granddaughter 5 Hillbrook Court Apt. 301; Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ò 4 Donation 5 □ Other (Specify) Hilltop Service Corp. 2/19/04 Towson, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road ever Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical myelon. Examiner Due to (or as a consequence of) Examiner certificete be executed buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last end Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physician I for use es the burie Physician/Medical Due to (or as a consequence of): ed by the e Part II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by 2/2 No 1 TYes 3 Probably 4 Unknown à 2 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete hes 1 ∐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NO > 1) U 21 No ٩ 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Man of Death 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred Attending Natural 5 Pending investigation deeth. 2 Accident 1 Tes 2 No d in by the 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) efter 4 ☐ Homicide Hospital or To the Hospital or within 24 hours eff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D40854 D Name and address of person who completed cause of death (Item 23a) (Type, Print) Rolf MD 21202 Mid

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

Fromm, Gloria

32. Registrar's signature

1 9 200

			1 - For State Registrar	State of M					9	004	0515
			Decedent's Name (First, Middle, L.)	ast)		Timodio or i	Douin		eg. 140.		3. Time of Death
	Physici		Robert	William	Feuka			Month Februar	Day	Year	10.00 P M
	/Medio Examir		4a. Facility Name (If not institution, ga			4b. City, Town, or	Location of Death	TCDIGAI			10:00 F
			4 Bandon Court,	Unit 301		Luthery	/ille		Ba1t	imore	
	Funeral			Sex 7. Ag		/ If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthpl	lece (State or Foreign
	Director		216-24-8055	IXM ZUF	76 Yrs.			Dec 28	1927		**
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	ocation				11	Od Inside City Limits
	Manyl f sho	5	26 2 1 2 2 1 2								•
	28a-	Director	Maryland Baltimo	re	Luthe			1	On Citizen of	What Coup	
	3a or	0	A Pandon Count I	In d + 201			102	'			
	72 hours after death with the Maryland netural; or Items 23a or 28a-1 show dicel Evant or must be notified at	Funeral	4 Bandon Court, I	12. Was Decedent	Ever in U.S. 13			ecify Yes or No-	7.		an Indian,
9	after or ite	F	1 Never Married 2 Married		No			Rican, etc.)			etc.
03	ours aft	i by	3 X Widowed 4 ☐ Divorced	Year or Dates:		1∟ Yes 2MM No	Specify:		Specif	v: W	hite
21215-0036	d within 72 hours : giene. er then "netural", c	Completed	15. Decedent's E (Specify only highest g		16a. Dec	edent's Usual Occupa	ation during most of worki	ina	16b. Kind of B	usiness/Ind	lustry
121	within lene. then	ig I	Elementary/Secondary (0-12)	College (1-4or	life	DO NOT use retired	)				
2	filed v Hygie ther t		12 17. Father's Name (First, Middle, Las		Co	rporate Sa					Forms
anc	B a B S	Be	_							,	
Maryland	d Meni d Meni marke matic	2	Joseph W. Fet		10h Ma	ling Address (Street					0.41
Ma	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		Laura Stevens/Dau								
ā,	Health tem 27 other tra		20a. Method of Disposition	ignicer	20b. Place of Dist	osition (Name of		Date			
J0	Pages nent of ant: if it		1 X Burial 2 ☐ Cremation 3 ( 14 ☐ Donation 5 ☐ Other (Spec		1		·   4/17/		n 1	,	
altimore,	그런런 중		21 Signature of Funeral Service Line	7-17	Daltimor	2. National 2. Name and Addres	. Cemetery	7	Baltimo	ore, M	Maryland
m	Departing Department of the partment of the pa		Bryan W. Clar	Mary		emmon Fun 10 W. Pado	eral Home nia Road.	of Dul	aney Va	11ley 2100	Inc.
			23a. Part1. Enter the disease, or con	nplications hat cau ec	the death. Do not e						Approximate
	Physician	17. 4	Immediate Caus (F) al disease or condition			myocme	RM 12	COURT			Onset and Death
1	/Medical		resulting in death)	Due to (or as	a consequence of):		//-	, -		-	
	Examiner		Sequentially list conditions,	b	DSCVD						11 years
	P #	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		' '	0					
	ecute and -trans	Examiner	that initiated events resulting in death) Last			nekeuse					11 years
8760,	cate be executed physician and the burial-transit			Due to (or as	a consequence or):						
387	physicate the the the the the the the the the t	dical		d							
9 x	death certific e attending p d for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				224 Day	ha as dation	
Вох	atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3						•
O.	that the de ed by the delached	hysi	9 Unknown	9□ Unknown							
0	requires that the leen signed by th hould be detache	by P				inderlying cause give	in in Part I.	23e. Did tob	acco use cont	ribute to the	cause of death?
īg	v require been sig shauld b	edk	MYELODY	SPLASIN	<u> </u>			1 □ Ye	s 2 🗆 No	3) Proba	bly 4 Unknown
000	aw requisite been 2 should	Completed								Were autop	sy findings available
ř	The law cate has b page 2 s	E O						perform	ed?	leath?	
ita	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of Death				
× ×	d s	2	1 ☐ Yes 2 💢 No	Hospital: 1   Inpatie	nt 2 ER/Outpatie	nt 3 DOA Othe	r: 4 Nursing Hon	ne 5∏ Reside	nce 6 Othe	er (Specify)	
ū	ing P	on:	27. Manner of Death  1 X Natural 5 □ Pending	28a. Date of Inju (Month, Da)	ry 28b. Time (		at 2	28d. Describe ho	w injury occurr	ed	
Sic	tend death tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be								
Division of Vital Records,	or Al	Certification;	4 Homicide determined	286. Place of inju	ury - At home, farm, s c. (Specify)	reet, factory, office	Death   Reg. No. 2004   0.5   5   5   5   5   5   5   5   5   5		Route Number,		
_	spital ours sours and meral		29a. Certifier 1X Certifying P	2 Date of Program   3 Tens of Death   10:00 P   10:00							
	e Hos 24 h Fur letely	Medical	(Check only 2 Medical Exe	miner: On the basis of	examination and/or in	vestigation, in my op	Peath   Reg. No.   2004   0.5   5   5   5   5   5   5   5   5   5		he cause(s)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	1		29c. License	number	29	d. Date signed	(Month, D	ay, Year)
	X		> LhA	July		D-	12550		Febru	ary 1	7, 2004
	18		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	Print)					
	1		James A. Quinlan,			d, suite	101A, Tow	son, Mar	yland	2120	4
¥.	Sta Registr		31. Date filed (Month, Day, Year)	64	ar's Signature	6.					
	riegisti	ell P	FEB 1 9 2004	per service	it About						

		_	1 - For State Registrar		State	of Ma	ryland / De	partmen <i>ertificat</i>				lental Hy	gier Reg. No. 2	904	0515
	Physici		1. Decedent's Name (F			ner						2. Date of De Month Februa:	Day	Year 2004	3. Time of Death 8:05 A.M
	/Medic Examin		4a. Facility Name (If no					4b. City,	Town, or	Location	of Death		4c. Co	unty of Deeth	
1			5330 Dors	ey Hal	1 RD					tt Ci			_ F	loward	
	Funeral		5. Sociat Security Num	ber (	. Sex 100 M 2 ☐ F	7. Age	(In yrs. last birtho	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birthr	place (State or Foreign ntry)
	Director		216-10-93		1)AN 201		87					11/09/	1916	MI	)
	pua ≱_		Usuat Residence of De 10a, State 10	Ob. County			10c. City, Town o	Location							Od. Inside City Limits
	dary!	ō	MD	Horron	1		r.	Llicott	· Cii	<b>-</b> * 7					1 ☐ Yes 2 🗖 No
	the 288-	rect	MD 10e. Street and Number	Howa1	. ц			10f. Zip		L y			10g. Citizen	of What Cou	ntry?
	With 3e or		5330 Dors	оч На	1 RD				21	1042				USA	
	Jeath Tas 23	Funeral Director	11. Marital Status	ey na.	12. Was De		ever in U.S.	3. Was Dece	dent of H	ispanic Or	rigin? (Spe	ecify Yes or No		Race - Ameri	
မွ	72 hours after death with the Maryland natural', or items 23e or 28a-f show licel Examiner must be modified at	Ē	t Never Married	2 Marrie		Forces?	lo	tr Yes, spec		in, Mexica Specify		Rican, etc.)		Black, White,	etc.
8	rel', c	by	3 Widowed 4	Divorced	Year or	Dates	WII	1 1 1 1 1 1 1 1	263,190	эрвину			Зр	ecify:	Mite
21215-0036	72 h	Completed by	15 (Specify	<ol><li>Decedent's only highest</li></ol>	Education grade complete	d)	(0	ive kind of wo	rk done d	during mo:	st of work	ing	16b. Kind	of Business/In	dustry
121	within ene. then	ldm	Elementary/Seconda	ary (0-12)	College	(1-4or 5	+)	e. <i>DO NOT</i> u: Owner	se retired	1)			Cator	Distr	ibuting
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au	d be ental ked o	To Be	William G							Τ.	.1111:	an R. S	Schmidt	_	
Maryland	should nd Men s marke umatic	-	19a. Informant's Name	-			19b. M	ailing Address	(Street			al Route Numb			Code)
	and 2 salth a n 27 is		Mary Diane	Pomai	zynski/	Daug	hter 203	St. 3	fames	s RD	Mar	riottsv	ille,	MD 211	.04
Je,	s 1 a of Hei item		20a. Method of Dispos	ition			20b. Place of D		ne of			Date	20c. Locati	ion - City or To	own, State
E	Pages nert of int: If it		1 🖎 Burial 2 🗆 0 ` 4 🗆 Donation 5 (			m State	Crest L	awn Men	ı.Gar	rden	02/2	1/2004	Marri	lottsvi	lle, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, If a Mystical Examinist mark to notified at once.		21. Signature of Funer	ral Service L	censee Lem	m o	, 1	22. Name an Sterlir	d Addres	ss of Facit shton	Sch	wab Fun Baltim	eral H	Home, I	inc.
	*		23a. Part1. Enter the shock, or heart for	disease, or d	omplications tha	t caused	the death. Do not								Approximate Interval Between
	Physician		Immediate Cause (Fir disease or condition				and	10 8	Je8/	Bira	for	asse	1	- 1	Onset and Death
	/Medical		resulting in death)	0	Due 1	o (or as	a consequence of)	i i	1	1	1				
	Examiner	_	Sequentially list condition if any, leading to imme	itions,	b			Hy	p>	Her	102	~			
	ed sit	Examiner	Cause. Enter Underly:	ediate ing urv	Due	o (or as a	a consequence of)	0.							
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9	tificat ng ph) as th	fed	.= ===												
Вох	th cer tendir r use	an/N	tF FEMALE: 23b. Was decedent pr				of pregnancy 2 Fetal death	3 ☐Ectopic p	egnancy	,			23d.	Date of delive	ery Day Year
	e dea he at	sici	in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown		4□Pre 9□ Un		time of death	5 Other (sp	pecify)				į	Mortui	Day real
P.0	law requires that the death certificas been signed by the attending to 2 should be detached for use as	Physician/Me	Part II. Other significa	ant condition	s contributing to	death hi	it not resulting in th	e underlying o	ause div	en in Part	1	23a Did	tobacco use	contribute to t	he cause of death?
ds,	signe	d by	S	ent	M/2	110	2	o amoonymig -			••		Yes 2□N		pably 4 Unknown
Records,	w require been si should b	Completed	Mind	1	100	0-			-			24a. Was	an 2	4h Were auto	psy findings available
Rec	o	E E	mary	<u> </u>	John	بعد	101					auto	ormed2	prior to co death?	mpletion of cause of
Vital		ပိ	25. Was case referred	) et	ent					OO Die	4 D4	1 ☐ Yes		1 🗌 Yes	212 No
Ξ		To Be	examiner?	-	Hospital:	] Inpatie	nt 2□ER/Outpa	tient 3 D	Oth	or.		h (Check only me 5□Res		Other (Specia	WASS. LIV.
of		i i	27. Manner of Death		28a. Da	te of Injur		e of 2	28c. Injur Wor	y at		28d. Describe			7/-
ion	Attending r death. ector: After by the fune	atlo	1 ☐Matural 2 ☐ Accident	5 Pending investiga		onin, Day	<i>r Yeer)</i> tnju	М		Yes 2	]No				
Division	er der recto	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could n determin	200. Pla	ice of thit	ury - At home, farm	street, factor	y, office				(Street and N	umber or Rura	al Route Number,
Ö	ital or irs afte ral Dir led in	Cer													
	To the Hospital or Attanowithin 24 hours after death To the Funeral Director:	edical	29a. Certifier 1 (Check only 2 one)	☑ Certifying ☐ Madicel E	xaminar: On the	the best of basis of anner sta		r investigation	, in my o	pinion, de	ath occurr	red at the time,	date and pla	ice, and due to	o the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and titt	te of certifier	a	191	100	29	c. Licens	e number	20		29d. Date si	igned (Month,	Dey, Year)
			•	19	-	-0	5		D	715	UL		2	11/10	<u> </u>
	9		30. Name and address	s of person v	GARG	My	eath (Item 23a) (T)	pe, Print) MA1	136	v C	401	CE (	N, B.	A170,	Dey, Year) Y Du)2/223
	St Regist	ate rar	31. Date filed (Month,	Day, Year)	1 9 200	-	ar Signature	& do	***	P					

			1 - For State Registrar	State of	f Marylan		artmen rtificate					leg. No.	<b>0</b> 04	05152
	Dhusial		1. Decedent's Name (First, Middle								<ol><li>Date of Dea Month</li></ol>	Day	Year	3. Time of Death
	Physicia /Medic		Bennett J.	Gitnick			1				Februar		2004	
<b>)</b>	Examin		4a. Facility Name (If not institution	•	nber)				Location o	of Death			inty of Death	
187			Shady Grove Hos					ockv:	ille If Under	24 Hre	0 D-11 -( Dist		ntgome	
	Funeral Director		5. Social Security Number 491–50–8986	6. Sex 1 ★ 2 ☐ F	7. Age (In yrs. 52	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day April 2	, Year) 2, 195	51 Mi	place (State or Foreign ntry) SSOURI
	pu k		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	v. Town or Lo	cation							10d. Inside City Limits
	ehor	ŏ		gomery		Derwo							:	XX Yes 2 □ No
	he M	Funeral Director	10e, Street and Number			DELWG	10f. Zip	Code				10a Citizen	of What Cou	ntry?
	with a or	Ö						0855					ed Sta	
	eath	era	15701 Kanawha		edent Ever in U	.S. 13.			spanic Ori	igin? (Spe	ecify Yes or No-		Race - Amer	
	ter d	F	1 ☐ Never Married 2 Marr	Armed Fo 1 ☐ Yes	rces? ▼[X] No						ecify Yes or No- Rican, etc.)	'	Btack, White	, etc.
336	ors al	þ	3 Widowed 4 Divorced	If Yes, Giv Year or D	/0		1 🗌 Yes	2 <b>X</b> No	Specify:			Spe	ecify: w	nite
21215-0036	within 72 hours atter death with the Maryland ane. than "natural", or items 23a or 28a-f ehow tha Madical Examiner must be multified at	Completed	15. Decedent			16a. Dece	dent's Usua	at Occupa	ation	t of worki	na	16b. Kind o	of Business/Ir	ndustry
215	thin 7	ple	Elementary/Secondary (0-12)	College (1	I-4or 5+)		kind of wo DO NOT u				9		hanica	
2	filed with Hygiene. other than	Son			-5	Cor	sult	ing F					ineer	ing
pu	al Hy	Be	17. Father's Name (First, Middle,	Last)							(First, Middle,	Maiden Sun	name)	
yla	Ment Ment arked	2	Edwin Gitnick						Jean					
Maryland	12 should be fill hand Mental H h and Mental H 7 ie marked ott traumatic ever		19a. Informant's Name/Relations								al Route Numbe			p Code)
	1 and Health tem 27 other tr		Mary T. Gitnic	k/ Wife	205.5	15/C			1 Cou		Derwood,		20855 on - City or T	oum State
ore	Pages 1 nent of H int: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Email 2 ☐ Ema	3 Removal from	State	cemetery, cre	matory or o	ther plac		0/1:				
Ë	Pactent:	1 6	* 4 □ Donation 5 □ Other (S	pecify)	For	t Line					1/04	brent	wood,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at Once.		21. Signature of Funerat Service	Licersee	Man		2. Name ar imple	addres	bute	y Fune	eral and	Crem	ation	Center
	00 F 4 0		Jame 0	. 17 al	xu)		040 F	locky	ville	Pike	eral and Rockvi	lle,	MD 2011	852 Approximate
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on e	ach line	in. Do not en	ter the mod	ie or dyln	g, such as	cardiac	or respiratory an	<b>65</b> 1,		Interval Between Onset and Death
}	Physician		tmmediate Cause (Finat disease or condition resulting in death)	_ a	HCU	rte	AV	19	The.	nlo	^ .			Hour S
at.	/Medical Examiner		resulting in deathy	Due to	(or as a consec	quence of):			11	. 1				
		Jan 1	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consec	JJ-C+	25	17	4/1	, th	5			
	ted	nine	cause. Enter Underlying Cause (Disease or injury that initiated events	<	/ /	0	L	- ·						
	axecu and al-tra	Examiner	that initiated events resulting in death) Last	C. Due to	(or as a consec	guenge of):	F( 9		art			<u> </u>		
120	death certificate be executed a sattending physicien and of for use as the burial-transit	cal		C <sub>d</sub>										
89	ificate g phy as the													
Вох	andin use	Physician/Med	tF FEMALE: 23b. Was decedent pregnant		tcome of pregni		]Ectopic p	regnancy				23d.	Date of deliv	,
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rd	w require been sign	ed									1 9	′es 2□N	o 3 □ Pro	bably 4 Unknown
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<u>Ö</u>	Attending r death. ector: After by the fune	atic	2 Accident investi	gation			М		Yes 2□			_		
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 200. Flace	of Injury - At hing, etc. (Speci	iome, farm, st	reet, factor	y, office			28f. Location (S City or Tow		umber or Rui	al Route Number,
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	the I hin 2 the I nplet	Med	one) 29b. Signature and title of certifie		ner stated.		20.	c Licens	e number			29d Date ei	gned (Month	Dav. Year)
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	+		Trill!	tan	ULU.			V	> ( )	180	1	25/4	eary (	51 200
	10		30. Name and address of person	who completed caus	se of death (Ite	m 23a) (Type,	Print)	/	N	1	, 1	100	2 1	57 2008
	W. 2 C		31. Date filed (Month, Day, Year)	177 yes	Registra Sign	ature /	OCKO	141	9	1a-51	anc	203	550	
	Sta Regist	ate rar	FEE	1 9 20041	Rose	Je Je	A STATE OF THE PARTY OF THE PAR	20/19 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Labla Amend Item #9,11,12,13,15,16a-b,17,18,19a-b,20a-c ner fh G329 3/24/04 tas 1 - Stete Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** February 3, 2004 9:55 AM Gary Goodenough /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 6005 Crawford Drive Rockville Montgomery 8. Date of Birth (Month, Day, Yea Oct 27, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min. Days Hours 100 M 2□ F 55 1947 219-46-6314 Washington, Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r then "naturel", or Iteme 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Montgomery Rockville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20851 6005 Crawford Drive USA by Funeral death unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married unk Maryland 21215-0036 1 ☐ Yes PAG No Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk-(Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Court Clerk Legal permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygiel Important: if Item 27 Is marked other th eny injury or other traumatic event, the once. unkunk unta 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be George Lebrick Goodenough Lois C. Crawford 19a. Informant's Name/Relationship (Type, Print) -unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Montgomery County Police Dept 18600 Walker's Choice Rd. 12 Montgomery Village, 20886 e. MD Guy G. Goodenough, Son 20a. Method of Disposition Baltimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State Metropolitan Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State 3/8/2004 Alexandria, Virginia 21. Sign to a of Euneral Price Licensee Ronal d S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 race Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AMERIOSCUPLOTIC CROTOURSCUAR DIGHTE Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760 Completed by Physician/Medical as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached P.0 the 9 Unknown 9 Dlinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, pe SCHIZOP HREMIN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ninknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner?

1 ∑Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DDA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sign ature and title of certifier DK326 FEBRUARY 13, 2004 One, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11125 POCKILE PING, BOCKLICET NO 10351 MARGOLIS, MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

9 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 16,2004 1000 A M Gills Februari Lee Clarence /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) **Examiner** HOSD, tal General Baltimore maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Md. Director 8-4-60 216-82-3878 Usual Residence of Decedent 10d. Inside City Limits Maryland 10c. City, Town or Location 10b. County 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. importent: if item 27 is marked other than "natural", or items 23a or 28e-f ehow any injury or other traumatic event, it a Medical Examinating fronting an once. X□Yes 2□No Baltimore Director Md. NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21217 1632 W. Lanvale Street Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Yes 2√2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Baltimore City 10th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gills Ballard Cecil Carrie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1632 W. Lanvale St., Baltimore, Md. Judy Gills Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2-21-04 Lansdowne, Md. Mt. Zion Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 la March F.H. East 1101 E. North Ave. ware 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bladder Carcinoma with Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner , Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit ract Wrinan and resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵ 23e. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation after death.

I Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funeral C
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 29c. License number Edwardo Wiveles Cabudenta MO 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edua 10 maryland Mirel J-00 mp B 1 9 32. Registrar's Signature 31. Date filed (Month, State 2004 FEB 2400 Registrar

04-1209

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are

State of Maryland / Department of Health and Mental Hygien

			1 = State Amend Item#1pe	erPHYG828 2/20/04 EW	Certificate of	Death	Re	g. No. 200	4 05155
	hysici		Decedent's Name (First, Middle, Last)     Warrick	warnick Snerman Gra	aves Jr.		2. Date of Death Month FEB	Day Ye	3. Time of Death
	/Medic	45.0	4a. Facility Name (If not institution, give s			Location of Death	1110	4c. County of D	
_	xamin	ei	4000 FAIRVIEW AVE	ENUE		ORE CITY	T 0 D 1 1 1 1 1 1 1 1	NA	Charles (Charles Esperiment)
	neral ector		217-30-0313	14 0DE	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country) Md
pur	<b>*</b>		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Maryla	a-faho iliieda	ctor	Md. NA	Bal	ltimore				Y☐ Yes 2☐ No
death with the Maryland	lbenu	Director	10e. Street and Number		10f. Zip Code	-	10	g. Citizen of What	Country?
death	ms 2	Funeral	4000 Fairview Av	12. Was Decedent Ever in U.S.	13. Was Decedent of H	5 ispanic Origin? (Sp	ecify Yes or No-		merican Indian,
rs after	nd other than "natural", or itams 23a or 28a-1 show event, it is Medical Examinational be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  TY□Yes 2□No If Yes, Give Year or Dates:	If Yes, specify Cuba	Specify:	HICAN, etc.)	Specify:	hite, etc. Black
72 hours	neture dical E		15. Decedent's Edu (Specify only highest grade	cation 16a. 16a. 1	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of work	ring	6b. Kind of Busine	ss/Industry
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ould be fill	marked matic ev	To B	Warnick	S Graves,	Jr.	Robert	a	Н	olmes
	item 27 le marke othar traumatic		19a. Informant's Name/Relationship (Ty	pe, Print) 19b.	Mailing Address (Street	and Number or Rui	al Route Number,	City or Town, Stat	e, Zip Code)
g € g	n 27 nar tru		Victoria Roles		1221 Deanwo			, Md. 2	
S			20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ P	temoval from State cemetery	Disposition (Name of y, crematory or other place	<b>e</b> )		0c. Location - City	
Pag	jury	- 25	* 4 ☐ Donation 5 ☐ Other (Specify)	Ma. V	/et. Cem.		20-04	Crowmsvi	lle, Md.
permit. Pages Department of	any in	5 13	21. Signature of Funeral Service License		March F.		Balti 11o1 E	more, Md . North	. 21202 Ave.
/Me Exan	To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and property of the funeral director.	Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Figure 1) that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to	of):	ierase	ellen L	Despars	Onset and Death
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Attending Phy rr death.	: After the tuneral		27. Manner of Death  1. Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 28b. Ti	njury Worl	rat (? Yes 2 □ No	28d. Describe how	w injury occurred	
l or Atte	Diracto d in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, family building, etc. (Specify)	rm, street, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	Rural Route Number,
To the Hospital within 24 hours	e Funara etely filler	edical C		sicien: To the best of my knowledge, ner: On the basis of examination and and manner stated.					
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	1		30. Name and address of person who co	104AN 111 Pe		Baltimore	e, Maryla	nd 21201	
4.	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature					

Registrar

FEB 1 9 2004 And A And

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Funera Directo		5. Social Security Number 6. Se			If Under 24 Hrs. 8. Date	of Birth h, Day, Year) ST &, 191	9. Birthpi Coun NOXTA	tace (Stete or Foreign try) CAROLINE
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th with th	Funeral Director	10e. Street and Number 2145 Home U	1000 AVE.		21218		n of What Coun	†.
I. Z. 13-UU30 within 72 hours after death with the Maryland ene. than "natural; or itams 23s or 28s-f show the Moulcal Examination of the Moulcal Examinatio	b	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♠ No ff Yes, Give Year or Dates:	13. Was Decedent of Hi ff Yes, specify Cubai	spanic Origin? (Specify Yesh, Mexican, Puerto Rican, etc Specify:		Black, White, o	
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MICE Y CALLO Z IN 4 2 should be filed with th and Mental Hygiene 7 is marked other tha traumatic svent, Itel	To Be C	17. Father's Name (First, Middle, Last)  MARSHAUL			18. Mother's Name (First, M			
and 2 should saith and Mer n 27 is marke		19a. Informant's Name/Relationship (7) ELORES 1467						
Ling Pa		20a. Method of Disposition  1 Surial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	cem	e of Disposition (Name of etery, crematory or other place)  22. Name and Address	Date  ARK 2.14.0	- 1	TIME,	
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6 be executed sician and e burial-transit	Examiner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to [or as a consequent c					
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DIVISION  el or Attending s after death.  al Diractor: Afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office		ion (Street and I or Town, State)	Number or Rura	l Route Number,
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To the within To the compl	Me	29b. Signature and title of certifier	mid	29c. License			signed (Month, L ary 7 20	
γ		30. Name and address of person who	Char.		enn Street, Ba	ltimore	, Maryl	and 21201
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	9				

Homer Gibson 04-00070 crn

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	/Medic Examin	al .	4a. Facility Name (If not institution, give	e street and numbe	or)				Location o	f Death	Januar	4c. County		6:50	_ A <sup>M</sup>
		<b>b</b> , , , ,	Maryland General  5. Social Security Numbernk 6. S		Age /In yes	last birthday)		altin	If Under 2	24 Hrs.	8 Date of Birt		V/A	place (State o	or Foreign
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212	d with	mo.		nk											
Maryland	ould be filed Mental Hygi arked other attic event,	To Be	17. Father's Name (First, Middle, Last)					unk	18. Mothe	r's Name	(First, Middle,	Maiden Suman	ne)		unk
ary	2 should and Men is marke eumatic	-	19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	r or Rura	Route Numbe	er, City or Town,	State, Zi	o Code)	
	and 2 salth a n 27 is		O.C.M.E.			111	Penn	Stre	et B	alti	more, M	D 2120	1		
Baltimore,	- H i		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 14 □ Donation 5 ☒ Other (Specification)	Removal from Sta	te C	Place of Dispo cemetery, crea			6)	D	ate	20c. Location	City or T	own, State	
Baltir	permit. Pages Department of important: If i any injury or once.		21. Signuture neral Service Sicer		rector	r Si	Name ar tate i	Anato	s of Facility	oard 21201	655 W.	Baltim	ore S	Street	
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Division	o ir te	Certification:	3 Suicide 6 Could not b 4 Homicide determined	289 Place of	Injury - At h etc. (Speci	iome, farm, st	reet, factor	y, office			28f. Location (5 City or Tox	Street and Numb vn, State)	er or Rur	al Route Nun	nber,
	te Hospitel	edical (	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exer	nysician: To the be miner: On the basis and manner	s of examina	owledge, deat ation and/or in	h occurred vestigation	at the time, in my of	ne, date an pinion, dea	d place, a	and due to the ead at the time,	cause(s) and madate and place,	nner as s and due t	stated. to the cause(s	s)
	within To th compl	Me	29b. Signature and title of certifier				29	c. License	number			29d. Date signe	d (Month,	Day, Year)	
			I his hi.	mi D				С	.C.M.	Ε.		January	4,	2004	
		54	30. Name and address of person who LING LI. M	•	of death (Ite	m 23a) (Type,		Penn	Stree	et, E	Baltimoi	re, Mary	land	21201	
100	Sta Regist		31. Date filed (Month, Day, Year)  FFR 1 9 20	11	istrar's Sign	ature	3000								

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY  $^{29}15, \ \underline{2004}9:00$ **Physician** GOLDBERG Η. DAVID /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LUTHERVILLE BRIGHTWOOD NURSING HOME BALTIMORE ME
7. Age (In yrs. last birthday)

RQ Yrs. Months Days Hours Min. NOV.13,1914 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2□F 213-03-4524 POLAND Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No BALTIMORE BALTIMORE Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ONE GARRISON FARM COURT 21208 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify WHITE þ 3 ☐ Widowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) PORTRAIT PHOTOGRAPHER **PHOTOGRAPHY** permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If item 27 Is marked other eny injury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **GOLDBERG** LENCZYCKA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7217 DENBERG ROAD - BALTIMORE, MD 21209 AVRUM GOLDBERG / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) HEBREW YOUNG MENS' 2/17/2004 WOODLAWN, MD ¹ 4 □Donation 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part . Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one says a on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Yfde ONDUNDA resulting in death) /Medical Due to (or as a consequence of): **Examiner** Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year ò Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 5 No Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has page 2 1 ☐ Yes 2 NO or Attending Physicien: completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Varsing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. s after death 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certiff 809 death (Item 23a) (Type, Print) 30. Name and address of person Batto, MD 21208 Rd 31. Date filed (Month, Day) State FEB 1 9 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		-	For State Registrar	State of N	Maryland		artment of H		nd Mental I		ne vo.20(	16	05159
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			Usuel Residence of Decedent						bune		1010		
	nylan how	_	10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits 1 ☐ Yes 2 🖔 No
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(0	fter d	표	1 ☐ Never Married 2 ☑ Marrie	Armed Force	s?	1	f Yes, specify Cuba	n, Mexican,	Puèrto Rican, etc.	)		, White,	
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ž	s 1 and 2 of Health a item 27 is other tree		Catherine S. Ha	11/Spouse				1d Roa		2; S:	ilver	Spr	MD20904,
ore			20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 □Bemoval from Sta	cen	ce of Dispo netery, cren	sition (Name of natory or other plac	e)	Date	20c.	Location - C	ity or To	own, State
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Baltimore,	permit. Page Department of Importent: if any injury or ance.		21. Signature of Funeral Service L	icensee Os Wu	(	Si 10	Name and Address Mple Trib 40 Rockvi	ss of Facility oute F 111e P	uneral am ike Rocky	ıd Cr ville	emation, MD	on C 2085	enter 2
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p	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		xaminer: On the basi and manner	s of examination	on and/or in	vestigation, in my op	pinion, deatl	h occurred at the tir	ne, date a	and place, ar	nd due to	the cause(s)
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	\		> >15	Im du	ease	1 Mp	D0023	649		Fe	bruary	17	, 2004
	6		30. Name and address of person v										
			John Stuckey 31. Date filed (Month, Day, Year)	3110 Grace	field istrar's Signal	Road	Silver Sp	ring,	MD 20904				
25	Sta Regist		FEB 1 9 2	2004	istrar's Sign	ASSE	755						

John Huff 04-00165 MAN

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physici	100	1 - StateUnpend Item #2 Registrat  1. Decedent's Name (First, Middle,						2. Date of Month	Death		Yeer	3. Time of De
/Media		John Huff						Janu		7, 20		0045 A
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Funeral		5. Social Security Number UNK	5. Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. las 47	st birthday Yrs.	Months Day	s Hours	Min. (Month	, Day, Yea	r)	9. Birthpl Coun	lace (State or Fo try) un
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nark matk	2	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mai	ling Address (Stre	eet and Numbe	er or Rural Route No	ımber, City	or Town, S	itate, Zip	Code)
In an		O.C.M.E.	, , , , , ,			Penn St		Baltimore,		21201		
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		•	For State Registrar	State	of Marylar	id / Depa <i>Cei</i>	artment of H	eaith ar D <i>eath</i>	nd Mental Hy	/giene Reg. No.	2001	+ 05161
11	*555	- 5	Decedent's Name (First, Middle						2. Date of D	eath		3. Time of Death
	Physici /Medic		Wilda	Fann	ie	Har	ris		Februa	Day 3rv8		10:22PM
	Examin		4a. Facility Name (If not institution				4b. City, Town, or				County of Deat	
			Frederick M			f 4 f * st- 1- 1	Frede:		Hrs. C. C		Freder	
	Funeral Director		5. Social Security Number 577–30–4579	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 87	Yrs.	Months Days		Min. 8. Date of B (Month, D Feb 8,	ay, Year)		thplace (State or Foreign buntry) UNK
5	*		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	cation					10d. Inside City Limits
farvia	shoy	ō		erick		rederi						1 ☐ Yes 2√☐ No
a d	28a-	Director	10e. Street and Number				10f. Zip Code		-	10g. Citi	zen of What Co	ountry?
<u> </u>	3e or st be	io ie	355 Monteview	Lane			2	1701		Ţ	JSA	
tode	ems 2	Funerai	11. Marital Status	12. Was De	ecedent Ever in U Forces?	.S. 13.	Was Decedent of H	ispanic Origin	n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Ame Black, Whit	
و م	and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, It a Maxical Examinational be nutilised at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	ied 1 ☐ Yes	s 2.2ÅNo Give		1 ☐ Yes 2X No	Specify:		!		hite
ocon-	fural		15. Deceden		Dates.	16a. Dece	dent's Usual Occupa	ation	un	k 16b. Ki	nd of Business	Industry unk
ה ה ה	n n Medic	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade complete	d) (1-4or 5+)	(Give	kind of work done on DO NOT use retired	during most o. I)	f working			,
7	giane	Com	unk	unk								
מחמ	d oth	Be	17. Father's Name (First, Middle,	Last)			unk	18. Mother's	Name (First, Middle Eula Smi		Sumame)	
2 2	J Men narke	၉	19a. Informant's Name/Relations	hip (Time Print)		10h Martin	a Address (Street	and Number	or Rural Route Num		r Town State	Zin Code)
Z	th and 17 is n traun		Frederick Memo		oital				Frederick		21701	inp Code)
<b>e</b> 3	of Health and Meritem 27 Is marke		20a. Method of Disposition		20b. I	_	sition (Name of natory or other place		Date	-	cation - City or	Town, State
o B	nt: If		1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☒ Other (S		m State	zametery, crei	natory or other place					
Baltimol	Department of blue portant: If its any injury or of once.		21. Signature of Funeral Service			r Si	Name and Address tate Anate	ss of Facility	ard 655 W I201	. Ba1	timore	Street
			23a. Part 1 Enter the disease, of shock or heart failure. List	complications tha	t caused the dear							Approximate
	hysician		Immediate Cause (Final	only one cause or	n each line.	tie u	i Fac	itis				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due t	to (or as a consec	uence of):	7	7. 7. 4				30000
4	xaminer		Sequentially list conditions,	6	Backe		ca'					3 week
7	3 15	ine	Sequentiany list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that individe events.									
	physician and sthe burial-transit	Examiner	that initiated events resulting in death) Last	c. Due t	to (or as a consec	quence of);						
8760,	siciar s buris	cai		d								
8	in phy as the	ed										
XO POX	e attending physician and od for use as the burial-trans	Physician/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pregn e birth 2 ☐ Feta	al death 3	∃Ectopic pregnancy				23d. Date of del Month	livery Day Year
С	the at	sici	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	4□Pre 9□Un	ignant at time of o known	death 5	Other (specify)				WORTH	Day Tour
<u>.</u> į	been signed by the s should be detached		Part II. Other significent conditi	ons contributing to	death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
Vital Records,	sign ed bi	d by	Dialetes	type.	11	-			1	Yes 2	<b>Z</b> No 3 □ Pr	robably 4 Unknown
ဝွ	as beer 2 shou	Completed		10					24a. Wa		24b. Were au	utopsy findings available
e g	stotall. The law certificate has I rector, page 2 s	ошо							aut per	opsy formed? 2 No	death?	completion of cause of
E E	rtifical	0	25. Was case referred to medica	1				26. Place of	f Death (Check only			
	D 12.	To B	examiner? 1 □ Yes 2 No			ER/Outpatier		4 Linuis	ing Home 5 Res			city)
ם פ	After th	on:	27. Manner of Death 1 Natural 5 ☐ Pendi	ng (M	te of Injury onth, Day Year)	28b. Time o Injury	Wor		28d. Describe	how injur	y occurred	
SIO.	or Attending rater death.  Director: After in by the funera	icat	3 ☐ Suicide 6 ☐ Could	not be 280 Pla	oce of Injury . At h	nome farm str	M 1 [	Yes 2 □ No		(Street an	d Number or Ri	ural Route Number,
Division of	after Direct Direct In by	Certification;	4 ☐ Homicide determ	nined 200. Fie	ilding, etc. (Speci	fy)	eet, factory, office			own, State		and House Wallious,
ñ	one hospital or at within 24 hours after of To the Funeral Direct completely filled in by	edical C	(Check only 2 Medical	Examiner: On the	basis of examin-				place, and due to the			
:	thin 2 the omplet	Med	one)  29b. Signature and title of certifie		anner stated.		29c. Licens	e number		29d. Dat	e signed (Mont	h, Dey, Year)
,	- 3 F 8		>0	7			84	3091			13-04	
			30. Name and address of person	- C			Print)		A		12 0	0 10
				Zeneli	an	80	1 Tou	Hou	se Av		Trade	rule Hop
8	St: Regist	ate	31. Date filed (Month, Day, Year FEB 1 9 2	nna Rea	. Registrar's Sign	ature	le			₹		
	riegist	T CII	LEDIJ	OUT PARK	C. F. C.	1						

		1 - State State Registrar	or Marylan		rtificate of	Health and M Death	ientai Hy	giene Reg. No. 20	04	05162
Physici /Medio		1. Decedent's Name (First, Middle, Last)  Randolph	Herman				2. Date of De Month Februa	Day	Year 2004	3. Time of Death 12:05 P M
Examin		4a. Facility Name (If not institution, give street and no		_		or Location of Death		4c. County		
		Greater Baltimore Medica  5. Social Security Number 6. Sex	7. Age (In yrs.		Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Balti		ace (State or Foreign
Funeral Director		590-25-4010 1 <sup>™</sup> 2□ F	26	Yrs.	Months Days	Hours Min.	8. Date of Bin (Month, Da March	12,1977	Countr Tri	ace (State or Foreign ry) nidad
yland Now		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10	d. Inside City Limits
ith with the Marylan 23a or 28e-f show	Director	Maryland Baltimore		Balti	more					1 ☐ Yes 2 X No
with th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	/hat Countr	ry?
death ms 23	Funerai	5705 N. Charles Stree	cedent Ever in U	.S.   13. <sup>1</sup>		1210 Hispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No	U.S. 14. Race	- America	n Indian,
1215-0036 within 72 hours after death with the Maryland one. one. Itan "natural", or itams 23a or 28e-f show the Maryland in	by	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, G Year or	orces? 2 🐧 No iive Dates:		lf Yes, specify Cub 1 ☐ Yes 2 ☐ <b>X</b> No		Rican, etc.)		k, White, e : Asia	
5-003	eted	15. Decedent's Education (Specify only highest grade completed	)	16a. Dece	dent's Usual Occup	pation during most of worki	ing	16b. Kind of Bu	siness/Indu	ustry
Ind 21215-0036 be filed within 72 hours af tal Hygiene. d other than "natural", or event, the Madical Exact	Completed	Elementary/Secondary (0-12) College	(1-4or 5+)		ore Mana			Reta	il	
Maryland 2 d 2 should be filed in and Mental Hygis 27 is marked other traumatic event.	Be C	17. Father's Name (First, Middle, Last)			or e mana	18. Mother's Name	e (First, Middle,			
	To	Ralph Herman				Zadha	Baks			
5 5 E ~ 3		19a. Informant's Name/Relationship (Type, Print)  Ralph Herman Fathe	\v			and Number or Rura				
s 1 and 2 f Health item 27 other tr		20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of natory or other pla	es Street	Date	20c. Location -		
Dallimore, Deamil. Pages 1 a Department of Her mportent: If item any injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	1 State		ervice Co	.	3-2004	Towso	n M	aryland
paritinore, permit. Pages 1 and Department of Heali Importent: If item 2 any injury or other once.		21. Signatura or a filma Service Licensee			2. Name and Address 2050 York			on Fune Marylan	ral H	ome, Inc. 204
*		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the deat each line.	h. Do not ent	er the mode of dyi	g, such as cardiac o	or respiratory ar	rrest,	1	Approximate Interval Between Onset and Death
Medical reached executed bhysicien and sthe burial-transit sthe burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	o (or as a conseq	uenc of):	AUV	n br	d aña			
Attending Physician: The law requires that the death certific releath. sctor: After this certificate has been signed by the attending py the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	utcome of pregna birth 2  Feta gnant at time of d nown	Ideath 3	Ectopic pregnanc Other (specify)	у		23d. Date Mor	of delivery	y Day Year
quires that the d	δ	Part II. Other significant conditions contributing to	death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contr res 2 <b>XX</b> No		cause of death?
The law require tale has been single page 2 should I	Completed						24a. Was autop perfo	rmed? d	Vere autops rior to comp eath?	sy findings available pletion of cause of
Vital Fincian: The certificate rector, pag	Be	25. Was case referred to medical examiner?			Tax	26. Place of Death	(Check only o	ne)		
DIVISION Of VITAI RECORDS, to Attending Physician: The law requires that recent.  Director: After this certificate has been signed in by the funeral director, page 2 should be a	tion: To	27. Many r of Death 1 Natural 5 Pending (Mo	npatient 2 e of Injury nth, Day Year)	ER/Outpatien 28b. Time of Injury	28c. injui Wo	ner: 4 \(\text{ Nursing Ho}\)  ry at rk?  Yes 2 \(\text{ No}\)		dence 6 Other		
in the second	Certification:	3 Suicide 6 Could not be determined 28e. Place	e of Injury - At he ding, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Numbe vn, State)	er or Rural I	Route Number,
Hospitel 24 hours 8 Euneral letely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the one) Medical Examiner: On the and ma	best of my know basis of examina nner stated.	wledge, death	n occurred at the till vestigation, in my o	me, date and place, opinion, death occurr	and due to the o	cause(s) and mar date and place, a	ner as stat nd due to t	ted. he cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed	(Month, Da	ay, Year)
()		PROCKY			1000	20000	4	2/11	00	4
1 8		30. Name and address of person who completed can Brian Roeder, M.D. 65				1103 Tow	son Ma	rvland	21204	1
Sta	ite	31. Date filed (Month, Day, Year) 32.	Registrar's signa	ture	DUI CE U TI	1100 IOW	Jon, Ma	ı yı anu	5150c	
Registr	ar	FFB 1 9 200	Million	and It	Angel	Jan Carlotte				

State Registrar

the

31. Date filed (Month, Day, Year) FEB 1 9 2004

dress of person

201

29b. Signature and title

32. Registrar's Signature

and manner stated.

111 Penn Street, Baltimore, Maryland 21201

Z M Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.ME.

29d. Date signed (Month, Day, Year)

February 12, 2004

hh (Item 23a) (Type, Print)

		1 - For State Registrar	State of Maryland	-	artment of H			giene 2 6	104	05164
Physic		1. Decedent's Name (First, Middle, Last)  Tick Dall			Hus	qin	2. Date of De Month	Day	Year CO4	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give s The Johns Hopk	(1)	-	4b. City, Town, or Balton			4c. Count		
Funeral Director		5. Social Security Number 6. Sex 578-15-0311  Usual Residence of Decedent	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ay, Yeer) 1942	9. Birthp Cour Ind	
Ba-f show	ector	MD 10b. County Prince G		Town or Lo	1e					0d. Inside City Limits 1X Yes 2 □ No
ath with ti	Funeral Director	10e. Street and Number 5017 Manheim Aven			10f. Zip Code 20705			10g. Citizen of Indi	a	
be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Itama 23e or 28a-f ahow avent, the Mudical Exa virial to incitified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Bla	ce - Americ ck, White, fy: Ind	etc.
d within 72 h giene. Ir than "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give lite.	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of wo	rking	16b. Kind of B		dustry
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic avent, ITE M. ONCE.	To Be C	17. Father's Name (First, Middle, Last) Aijaz Husain				Azeez	me <i>(First, Middle)</i> Fatima			
and 2 sh lealth and im 27 le m		19a. Informant's Name/Relationship (Ty, Rahat Iqbal / so	n	5017	ng Address (Street a Manheim sition (Name of			11e, Ma	rylan	d 20705
mit. Pages 1 partment of P portant: If ite y injury or ot		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State Geor	metery, crer ge Wa	natory or other plac shington	Cem 02,	/15/2004		, Mar	yland
permit. Departr Importa		21, Signjature of Funeral Service License	art M01378	7	2. Name and Address	Spring	Road, La	aurel, 1		and 20707
Physician /Medical		23a. Part1. Enter the lisease, or complishock, or heart milure. List only or immediate Cause (Final disease or condition resulting in death)	ne cause on each line.  Metustutic  Due to (or as a consequ	59V			-			Approximate Interval Between Onset and Death
te be executed ysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Doe to (ог аз а солѕеци							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□	Ectopic pregnancy Other (specify)				ite of delive	ory Day Year
w requires that been signed by should be detailed	by	Part II. Other significant conditions con	ntributing to death but not resu	lting in the u	nderlying cause give	en in Part I.	23e. Did t	_	tribute to th	ne cause of death?
Physician: The law requir Physician: The law requir this certificate has been si al director, page 2 should	Completed						24a. Was autor perfo 1 \( \text{Yes} \)	psy ormed?	prior to cor death?	psy findings available inpletion of cause of
Physician: This certifica	To Be	1 1 162 5 X 140		R/Outpatier		or: 4 🗆 Nursing l	ath (Check only o		ner (Specify	1)
eath. or: After the funera	Certification:	27. Manner of Death  1 Natural  5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at :? ∕es 2 □ No	28d. Describe I	how injury occur	red	
To the Hospital or Attending Physician: The Within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,				City or To			
he Hosp in 24 hou he Fune pletely fi	edical	29a. Certifier  (Check only one)  1  Certifying Physical Check only one)	sician: To the best of my knowner: On the basis of examinati and manner stated.	rledge, death on and/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and made and place,	anner as st and due to	ated. the cause(s)
To t To t	Σ	29b. Signature and title of certifier	Medical I	octo	29c. License	number		29d. Date signe		-
7		30. Name and address of person who co Neil Aggarwal, The	impleted cause of death (Item	23a) (Type,	Print)					
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Schalt	ILO.				· · · · · · · · · · · · · · · · · · ·		

ORIGINAL

Rosens Skiginhearths

Registrar

			For State Registrar		State of	Marylar			nt of H		and M	ental Hy	giene Reg. No.	20(	) 4	05	166
	Physici /Medic		1. Decedent's Name (First, N	Joh	1000	1						2. Date of De Month 2_	Day	2-00	ear 9	3. Time of	Death M
	Examin	er	4a. Fecility Name (If not institution of the second of the security Number of the second of the seco	AU 6. Sex	JUNUS	7. Age (In yrs.	last birthday	CE	y, Town, or ler 1 Year	Location of		8. Date of Bir	A	County of	310	ace (State o	or Foreian
H	Funeral Director		·	۵,۰	M 2020F	60	Yrs.	Month	s Days	Hours	Min.	8. Date of Bin (Month, De Apr 11		1	Count	land	
	and w	}	Usual Residence of Deceder 10a. State 10b. Co			10c. Ci	ty, Town or L	ocation							10	d. Inside C	ity Limits
	Manyl fede	ō	MD Hov	vard			Elkrid	Te								1 Tyes	2 <b>X</b> No
	28a-	reci	10e. Street and Number	var a			J_1,		ip Code				10g. Citiz	en of Wha	at Count	ry?	
	h with	O Te	6730 Deep Rur	n Park	way				21075				Uni	ted S	State	es	
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, liem 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinations in publical at	I by Funeral Director	11. Marital Status  1 Never Married 2 3 Widowed 4 Privo	Married	12. Was Dece Armed For 1 _Yes If Yes, Give Year or Da	ces? 2 <mark>∑</mark> No e		If Yes, sp	edent of H secify Cuba 2 1 No	ispanic Origin, Mexican Specify:	i, Puerto F	cify Yes or No Rican, etc.)	1	4. Race -	America White, e	ın Indian,	
21215-0036	thin 72 h e. an "natu Medical	Completed	15. Deci (Specify only h Elementary/Secondary (0-			-4or 5+)	(Give	kind of	ual Occup vork done d use retired	during most	t of workir	ng .	16b. Kin	d of Busin	ness/Indi	ustry	
2	ed wil	Con			2		Unde	erwr:	iter			_		uranc	e_		
Maryland	ould be filed a Mental Hygie arked other i	To Be	17. Father's Name (First, Mic Thomas Carl I		Sr.							(First, Middle, Eliza			osk	ey	
	nd 2 should be with and Mental 27 is marked r traumatic ev		19a. Informant's Name/Rela Judith Mille:					-				Route Numbert City				Code)	
nore,	ages 1 and 2 nt of Health of t: If item 27 i		20a. Method of Disposition 1 □ Burial 2 ☑ Cremat		emoval from S	State	Place of Disponentery, cree	matory o	r other plac			-2004		ation · Ci			
Baltimore,	permit. Pages 'Department of Himportant: If ite eny injury or of once.		21. Signature of Funeral Ser		-WHL	M01044	2	2. Name	and Addres	ss of Facilit	y Harr	y H. W ke Ell	itzk	e's F	ami.	ly FH	
	Physician		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition	e, or compli List only or	ne cause on ea	aused the dea ach line.	^					respiratory a	rrest,			Approximate Interval Bet Onset and	ween
	/Medical Examiner	er	resulting in death)  Bequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			or as a conse											
8760,	death certificate be executed e attending physician and nd for use as the buriat-transit	at Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			or as a conse	quence of):										
687	physicate physicate	edical			j												
.O. Box (		Physician/Me	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t 2		rth 2 □ Feta ant at time of	al death 3 (	⊒Ectopic ⊒ Other (	pregnancy (specify)				2	3d. Date of Month		•	Year
S, D	es tha	by	Part II. Other significant con	ditions cor	ntributing to de	ath but not re	sulting in the u	underlying	cause give	en in Part I.		23e. Did t	_		te to the	e cause of o	death? Unknown
Record	The ate h page	Completed										24a. Was autor perfo		prio dea	r to com th?	sy findings pletion of o	
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to me examiner?	-	In a six als				-		of Death	(Check only o	ne)				
of	Physician: this certific ral director.	2	1 Yes 2 No		-		ER/Outpatie			4 🗆 140		ne 5 Resident			(Specify)	)	
Division (	ling After	ation	Z Accident	restigation	28a. Date o (Monti	h, Day Year)	28b. Time o Injury	M	28c. Injun Worl	yat k? Yes 2 ☐ I		8d. Describe I	now injury	occurred			
Divis	in Siring	Certification:		ould not be itermined	28e. Place buildin	of Injury - At h	nome, farm, st	reet, fact	ory, office		2	8f. Location (3 City or Tox		/ Number	or Rurai	Route Nun	ber,
	To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	Medical			sician: To the ner: On the ba and mann	isis of examin											s)
	To the within 2 To the complet	X	29b. Signature and title of ce	rtifier	) ,/ /	1/			9c. Licens					signed (/			
	3		30. Name and address of pe	W- I	Se while of cause	e of death (Ite	m 23a) (Type	Print)	D38	3509		lumb,	reha	luxa	51	8 21	204
	\		Michilas Jul- A	soutie	14000	1065 C		PATE	itent	Pky	61	lumb,	14 /	Mary	Ken	121	044
	Sta Regist		FFR 1 9		122	Superior	19	In	- W-1								

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month February 17 v.v. Month Dey Physician SERALD EDWARD 08:50 am /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner MARIS HOSPICE BAUTIMORE If Under 24 Hrs. ff Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days .48.1996 10 M 2□ F Months Hours Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 No MDFuneral Director 10f. Zip Code 10e Street end Numbe 10g. Citizen of Whet Country? 21218 4.5.A. KIRK 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Merital Status 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1 Yes 2 No Specify. Be Completed by 3 ☐ Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) IRANS PORTATION DRIVER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JONES ERNESTINE WALTER DU BOSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ERNESTINE BALRET SISTER 1415 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State CALVERY CEMETERY 2.19.04 BACTIMORE MARYLAND 22. Name and Address of Fecility VANCHAM C. SPEENE TUNERAL HOME 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License. 4905 YORK ROAD BAIT, MORE, MARYLAND 21212 23a. Pert1. Enter the distale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Betwo Immediate Ceuse (Final disease or condition resulting in death) Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ģ 24b. Were eutopsy findings available prior to completion of cause of deeth? Be Completed 24a. Was en autopsy nellits 2 1 No 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Piece of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice 1 Yes 2 No 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Netural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760

I or Attending Physician: The law raquires that the death certificate be executed affar death.

Director: Affar this cartificate has been signed by the attending physician end in by the Innest director, page 2 should be detached for use as the buriel-trensit if in by the Innest director, page 2 should be detached for use as the buriel-trensit

**Funeral** 

Director

Herne

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is marked other than

Demnit. Pages 1 and 2 should be files.
Department of Health and Maniel Hygis important: if item 27 is marked any injury or other.

**Physician** /Medical

Examiner

المال Baltimore, M

To the Hospital or A within 24 hours aftar To the Funeral Directornial of the completely filled in b

Medical Certification: To 2 Accident 3 Suicide 6 Could not be determined 4 Homicide 29a. Certifier 29b. Signature and title of certifie

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

PIACE

PAUL

30. Name end address of p who completed cause of deeth (Item 23e) (Type, Print)

MARUK FELDMAN

·MD. 32. Registrer's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) FEB 1 9 2004

State

Registrar

			1 - State of Maryland	/ Depa	artment of Health ar tificate of Death	nd Mental Hy	giene 2	004	05168
Ī	Physici		Decedent's Name (First, Middle, Last)     Julia R. Ka:	1		2. Date of De Month Feb.	Day	0 0 4 eer	3. Time of Death
	/Medic Examir		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or Location of			nty of Death	1.30 A
			906 Foxcroft Lane		Essex		Bal	timor	· A
	Funeral		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. la.</i> 21.4 – 20 – 5.6.28 1 □ M 2♀ F	• • •	If Under 1 Year   If Under 24	Hrs. 8. Date of Bir Min. (Month, Da	th		lace (State or Foreign
	Director		214-20-5628 1□M 2√2F 80  Usual Residence of Decedent	Yrs.		July4	,1923		issippi
	/land			Town or Lo	cation			1	Od. Inside City Limits
	Man Hind	tor	MD Baltimore	Esse	x				1 ☐ Yes 2√☐ No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. Citizen o	of What Coun	try?
	hours after death with the Maryland urel', or Items 23a or 28e-f show in Exercities rough be notified at	rai	906 Foxcroft Lane		21221		USA		
	er de Items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hispanic Origir 'Yes, specify Cuban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)		lece - Americ lack, White,	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【5 No If Yes, Give 9 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1	☐ Yes 2 ☑ No Specify:		Spec	<i>™</i> Whit	е
Š			15. Decedent's Education	16a. Deced	ent's Usual Occupation		16b. Kind of	Business/Ind	Justry
21215-0036	filed within 72 Hygiene. other than "nel	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. L	kind of work done during most o OO NOT use retired) 1-	f working	Doot		_
	ygien ygien her th	Con	8th				L.,	auran	<u> </u>
and a		Be	17. Father's Name (First, Middle, Last)			Name (First, Middle	, Maiden Sum	ame)	
Maryland	should be nd Menta marked umatic ev	은	unknown 19a. Informant's Name/Relationship (Type, Print)	10h Mailin	g Address (Street and Number of	nown	na Cita au Tau	- 0-4- 7	0.4-1
<u>8</u>	d2 s h an 7 is treu		Beverly Kail / daughter		Foxcroft La				Code)
<u>6</u>	ーゴッシ		20a. Method of Disposition 20b. Plan	e of Dispos	sition (Name of patory or other place)	Date	20c. Location		wn, State
Ê	Pages nent of int: If it				11Cemetery 2	/20/04	Balt	imore	MD
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licensee	22	Name and Address of Facility	G11	_	7	
n 	89 5 5 9		K. Terry Connelly		300 Mace	Ava Ral	timor		eofEssex
			23a. Part 1. Enter the disease, or contributions that caused the death. shock, or heart failure. List only one cause on each list.	Do not ente	or the mode of dying, such as ca	rdiac or respiratory a	rrest,	C MD	21221 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	I V	nevoracheal	whale	H-		Onset and Death
	/Medical` Examiner		resulting in death)  Due to (or as a consequence)	nce of):		all de	Pres	1 2	years
		-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	uuu ma of):	in ainease	> ou	7101	7	·
	nsit	Examine	cause. Enter Underlying Cause (Disease or injury	11	heast Cus	1801000			
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2/PU	icate be e) physicien s the buria	dicai	<b>L</b> 4						
O	death certificate te attending phys	40	IS STAMPS						
X Q Q	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the cast 12 meeths?  1 □ Live birth 2 □ Fetal december 1 □ Live birth 2 □ Fetal december 2		Ectopic pregnancy			ate of deliver	
	the dea y the at tched fo	sici	in the past 12 months? 1 □ Yes 2 0 Mo 9 □ Unknown  in the past 12 months? 4 □ Pregnant at time of deal 9 □ Unknown		Other (specify)			Month i	Day Year
Ţ.	that the de led by the a detached f		Part II. Other significant conditions contributing to death but not resulti	na in the un	darhina asusa suca in Dart I	220 Did t			
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	ifficate or, pa	e Cc	25. Was case referred to medical		00 Plans 4	1 □ Yes	2 No		2 No
>	Physicien: this certific ral director,	To B	examiner?	VOutpatient	Other	Death /Check only on g Home 5 1 esic	-11	ther (Specify)	
0	ng Ph ter th			Bb. Time of Injury	28c. Injury at Work?	28d. Describe i			
200	eath. or: Al	catle	2 Accident investigation	,=.,	M 1 ☐ Yes 2 ☐ No				
DIVISION	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)	e, farm, stre	et, factory, office	28f. Location (5 City or Tow	Street and Num m, State)	ber or Rural	Route Number,
	pitel ours a eral [		29a. Certifier 1 Certifying Physician: To the best of my knowle						
	To the Hospitel or Attending Physicien: whithin 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle check only one)  1 Certifying Physician: To the best of examination and manner stated.	and/or invi	occurred at the time, date and pastigation, in my opinion, death of	place, and due to the opecurred at the time,	ause(s) and made date and place	nanner as sta , and due to	ted. the cause(s)
	To the Mithin To the Somple	Me	29b. Signature and the of certifier	\	29c. License number		29d. Date sign	ed (Month, D	ay, Year)
	ſ		· Mellymeca Mil	7	010613	,	2-18-	04	
	И		30 Name and address of per o who completed cause of death (Item 2:	Ba) (Type, F		A . A	ρ.	11/2	Λ.
			KAPHEL PEREL-MERA	400	f chstern	ISLUI).	BAL	TO IM	1)2/22/
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signatur FEB 1 9 2004	9					
			· LU - U LUUT JOS JOS	200	Mal				

			1 - For State Registrar	State of Maryl		artmer			nd Mental H	Hygien	e 2001	+ 05169
	Physic	ian	Decedent's Name (First, Middle, Last)     SUKHWINDER KAU						2. Date of Month	Death D	ay Year	3. Time of Death 10:13p M
Asy of	/Medi Examir		4a. Facility Name (If not institution, give s FORT WASHINGTON H	street and number)		1		Location of E		4	13,2004 c. County of Dea RINCE GE	th
	Funeral Director		217-13-9307	7. Age (In M 2 F 54	yrs. last birthday Yrs.	Months	Days	If Under 24 Hours	Min. 8. Date of NOV •			thplace (State or Foreign puntry) INDIA
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD PRINCE GE		City, Town or L		N.					10d. Inside City Limits
	h with the 23a or 28e	ai Director	10e. Street and Number 1713 BLOUNT DRIVE				p Code 20744				Citizen of What Co	ountry?
036	72 hours after death with the Maryland fratural, or tlems 23a or 28e-f show disal Examinar must be notitied at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	in U.S. 13.	Was Dece If Yes, spe 1 \( \text{Yes}	crfy Cubar	spanic Origin n, Mexican, F Specify:	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, White Specify: AS	te, etc.
121	within 72 ho iene. r than "natur rhe Medical I	Completed	15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0·12)	cation e completed) College (1-4or 5+)	(Give	dent's Usu kind of we DO NOT L	ork done d	uring most of	f working		Kind of Business	/Industry
0	2 should be filed and Mental Hygis is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last)  BALWANT S. AULAKH		'		1		Name (First, Mid DER K. AU		en Sumame)	
ē,	t and 2 shut Health and tem 27 is mother traum		19a. Informant's Name/Relationship (Ty PARMINDER SINGH/S 20a. Method of Disposition 1 □ Burial 2∑Cremation 3 □R	ON 20 temoval from State		BLOUI	NT DR	FT.W	OF RUFAL ROUTE NU  VASHINGTO  Date  -15-04	ON , MD		Town, State
Baltimore,	permit. Pages Department of Important: If I any injury or once.		*4 □ Donation 5 □ Other (Specify)  21 Signature of Funeral Service License	i	338 2	2. Name a	nd Addres	s of Facility	FLECK FU	NEKA	L HOME I	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart affure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (c. as a co.	Isequence of):	ter the mo	de of dying	n, such as car	rdiac or respirator	y arrest,		Approximate Interval Between Onset and Death
	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/Medical E	in the past 12 months?  1 Yes 2 DNo 9 Unknown	d. 3c. If yes, outcome of pre 1 □ Live birth 2 □ If 4 □ Pregnant at time 9 □ Unknown	Fetel death 3[ of death 5[	⊒Ectopic p ⊒ Other (s <sub>i</sub>	pecify)				23d. Date of del Month	Day Year
ords, l	w requires tha been signed should be det	by	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	inderlying (	cause give	n in Part I.			_/	o the cause of death? obably 4  Unknown
	The la ate has page 2	Completed								itopsy informed?	prior to death?	itopsy findings available completion of cause of 2 No
o	ding Phys	tion; To Be	25. Was case referred to medical examiner? 1	dospital: Despatient  28a. Dale of Injury (Month, Day Yea	2 ER/Outpatie		28c. Injury Work	r: 4 🗆 Nursir	Death (Check on ng Home 5 R 28d. Descri	esidence	6 □Other (Specury occurred	cify)
É	or Al	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.		reet, factor				n (Street a Town, Sta		ıral Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)  Certifying Physical Examination	ner: On the best of my ner: On the basis of exam and manner stated.	knowledge, deal nination and/or in	th occurred	at the time i, in my op	e, date and p inion, death o	place, and due to to occurred at the time	he cause( ne, date ar	s) and manner as nd place, and due	stated. to the cause(s)
•	Veith Veith Con	M	29b. Signature and title of certifier			29	c. License	number 743/		29d. D.	ate signed (Monti	h, Day, Year)
	2		30. Name and address of berson who co	JNO 1179	4 bruch	Print)	N-	#103	FT- W4	ship	no mi	20144
	Sta Regist		31. Date filed (Month, Day, Year)	1 9 20 popistrar's	ignature	C A	soul.	3				

		1 - For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment rtificate	of Hea	alth and	d Ment	al Hygio	ene 2	004	05170
Diam'r.		1. Decedent's Name (First, Middle, Last)						2. D	ate of Death Ionth	Day	Year	3. Time of Death
Physicia /Medic		Lutz Leopold			,			Fe	bruary		2004	12:20 ам
Examin		4a. Facility Name (If not institution, give st	treet and number)				cation of De	eath		4c. Cour	nty of Death	
		Manor Care Nursing				thesd		,		1	Montgo	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. M 2□F 76	last birthday) Yrs.	If Under Months		Under 24 H lours M	lin. B. D.	ate of Birth Nonth, Day, 1 b 8,	(ear)	Cour	
Director		210 20-2377	70	115.				ге	D. 0,	1928	Ger	many
and and		Usual Residence of Decedent  10a. State 10b. County	10c. C	ty, Town or Lo	cation						1	0d. Inside City Limits
Aaryl sho	5	MD Montgor	merv T	Rockvil	1e							1√D Yes 2 □ No
28e-	ect	10e. Street and Number			10f. Zip	Code			10	g. Citizen c	of What Cour	ntry?
with the or	Funeral Director	10101 Grosvenor Pi	lace: Ant. 13	201	2	0852				IIn:	ited S	tates
heath me 23	era		2. Was Decedent Ever in U	J.S. 13.	Was Deced	ent of Hispa	nic Origin?	(Specify )	res or No-	14. R	ace - Americ	can Indian,
ifter of	표	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	i			Mexican, Pu	ieπo Hican	, etc.)		lack, White,	
el', o	b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2	X No S	Specify:			Spec	ory:	White
72 ho natur	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	kind of wor	l Occupation	n ng most of v	working	10	6b. Kind of	Business/In	dustry
ithin Ber	npie	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT us		c		1	Educ	cation	
ygier yerth	Š		+5	Univ	ersit		fesso	-				•
d oth	Be	17. Father's Name (First, Middle, Last)				18		7,7112	t, Middle, Ma	alaen Sum	ame)	
Men Merke arke	ို	Max Leopold						Schu				0.11
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28s-f show amy injury or other traumatic event, I're Medical Examination and Leanedlifed at ODGs.		19a. Informant's Name/Relationship (Typ										<sup>Code)</sup> 20852
and fealth m 27 her ti		Gwen E. Leopold/ V		IUI Place of Dispo			or Pla	ace,	_		ROCKV n - City or To	ille, MD
t of H If its or ot		20a. Method of Disposition 1 Buriai 2XXC remation 3 Re	emoval from State	cemetery, crei	matory or of	ther place)						
tment: tant: jury		`4 □Donation 5 □ Other (Specify)		t Line			Ţ	2/12/			twood,	
permit Depart Import any In		21. Signature of Fuheral Service License	"/Alland	2 Cr	2. Name an	d Address o	f Facility	Simpl	e Trib Rockv	ute I		
00700		Mui J. M	reeves !								MD 2	ogockville
	ш	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	eations that caused the dea e cause on each line.	th. Do not en	er the mode	e o totylng, s	uch as card	diac or resp	oratory arres	it,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	Atherosc1	erotic	Disea	se						
/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):								
Examine	L	Sequentially list conditions, if any, leading to immediate									_	
sit sit	ine	cause. Enter Underlying	Due to (or as a conse	quence or):							-	
ate be executed hysician and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conse	nuence of):							-	
cian curial	caiE		200 10 (0. 00 0 00.00	4401100 01).								
ficate   physics the t	-	d										
ding I	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregr	ancv						234 [	Date of delive	201
atten atten for us	ian	in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	aldeath 3	Ectopic pro						Month	Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	36au 36	_ On 60 (ap	501197						
that the death certifica ed by the attending ph detached for use as th	P	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying c	ause given i	n Part I.	2	23e. Did toba	cco use co	ontribute to t	ne cause of death?
w requires t been signe should be	d by	Dementia							1 ☐ Yes	2 🔯 No	3 Prot	ably 4 Unknown
requ been shoul	ete								24a. Wasan	241	. Were auto	psy findings available
has be 2	Completed							-   `	autopsy	i		mpletion of cause of
n: Th icate r, pag										□ No	1 🗆 Yes	2 No
Physician: The law r this certificate has b rral director, page 2 s	Be	25. Was case referred to medical examiner?	ospital:	7500:		Other			eck only one		M (0)	
Phys this ral di	5	1 ☐ Yes 2 ☒ No ''  27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time o		A			5 Resident Describe how			y)
ding After fune	Fi	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	м	8c. Injury at Work? 1 ☐ Yes	2 □ No					
deat deat ctor: y the	Certification;	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At I	nome, farm, st	reet, factory						mber or Rura	al Route Number,
after Dire	erti	4 Homicide determined	building, etc. (Spec					6	City or Town,	State)		
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funaral Director: Atter this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as it		29a. Certifier 1 X Certifying Phys	ician: To the best of my kr	owledge, deat	h occurred	at the time,	date and pla	ace, and d	ue to the cau	ise(s) and	manner as s	tated.
24 h 24 h Fur etely	Medicai		ner: On the basis of examination and manner stated.									
To the within To the compl	₹	29b. Signature and title of certifier	/		290	. License nu	umber	······	29	d. Date sig	ned (Month,	Day, Year)
⊢ s ⊢ ō		> / Ild Alat	>		ת	00556	94		Ι.	ahrus	2737 11	, 2004
5		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Tvne		00000	<i>)</i>			entus	ary II	, 2004
			4000 Olney-La			Road:	01ne	y, MD	20832	2		
Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign			,		, , , , , , ,				
Regist		FFB 1 9 2004	La Cura	S. AD	NOTE !							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2001

		Registrar  1. Decedent's Name (First, Middle, Last)	)		rtificate of De		2. Date of Dea		3. Time of Death
Physici	an		11o Leon				Month January	y 29, 2004	
/Medic Examin	_	4a. Fecility Name (If not institution, give			4b. City, Town, or Lo	ocation of Death		4c. County of D	
LXuiiii	Ĭ	Shady Grove Advent	ist Hospit	:a1	Rockvil			Montgome	
Funeral Director		217-11-4120	M 2DE	(In yrs. last birthday 39 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug. 2		Birthplace (State or Foreign Country) Peru
and w		Usuel Residence of Decedent  10a, State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
daryti f sho	ō	Maryland Montgome	277	C	aithersburg	r			1 X Yes 2 □ No
the 1	Directo	Maryland Montgome  10e. Street and Number	i y		10f. Zip Code	,	T .	10g. Citizen of What	Country?
3a or		445 West Diamond A	venue: Ant	Т2	2087	77		United St	ates
deat	Funeral		12. Was Decedent Ev Armed Forces?		Was Decedent of Hisp If Yes, specify Cuban,		ecify Yes or No-	14. Race - A Black, W	merican Indian,
permit. Pages 1 and 2 should be lifed within 72 hours after death with the Marylan's Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Buy injury or other traumatic event, if a Meulcal Exacities must be notified at Once.  Once.	٥	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1X Yes 2 No				Caucasian
natur	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dece	edent's Usual Occupation be kind of work done during DO NOT use retired)	on ing most of work	ring	16b. Kind of Busine	ss/Industry
ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+	)					
ygier ygier her th	S	7 17. Father's Name (First, Middle, Last)		Bus	Driver	R Mother's Nam	e /First Middle	Transport Maiden Sumame)	ation
be fil	Be				10	_	_	maiden demand)	
J Mer J Mer nark	ဥ	Eulogio Tello  19a. Informant's Name/Relationship (T)	(na Print)	19h Maii	ling Address (Street and	Tomasa		r City or Town State	a Zin Code)
d 2 si th and 7 is r traur		Carolina Tello/Spo			-				ourg, MD 2087
1 an Heal tem 2		20a. Method of Disposition		the same of the sa	osition (Name of omatory or other place)		Date	20c. Location - City	
ment of tent: If it jury or o		1 X Burial 2 ☐ Cremation 3 ☐ S 4 ☐ Donation 5 ☐ Other (Specify,		All Soul	ls Cemetery			Germantow	
Departition Depart		21. Signature of Funeral Service Lipens	Dom		Simple Trib 1040 Rockvi	llle Pik	e; Rocky	ville, MD	Center 20852
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused to ne cause on each line	he death. Do not er	nter the mode of dying,	such as cardiac	or respiratory ari	rest.	Approximate Interval Between Onset and Death
hysician		Immediate Cause (Final disease or condition	Esopha	geal Sten	t Obstructi	Lon			Onset and Death
/Medical		resulting in death)	Due to (or as a	consequence of):					
Examiner		Sequentially list conditions			of Esophag	gus			
D 15	ine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	consequence of):					
xecute and al-tran	Examiner	that initiated events resulting in death) Last	C	atic Blad consequence of):	er Cancer				-
eath certificate be executed attending physician and for use as the burial-transit	edical E		d						
ding p		IF FEMALE:	23c. If yes, outcome o	foregoancy				22d Date of	dolhan
requires that the death cer een signed by the attendin culd be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
that if	Ph	Part II. Other significant conditions co	intributing to death but	not resulting in the	underlying cause given	in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
sign d be	d by						1 🗆 Y	′es 2□No 3□	Probably 4 X Unknown
> 0	Completed						24a. Was	an 24b. Were	autopsy findings available
e la has	E C							rmed? death	
ician: Th certificate ector, pag	ပို	25. Was case reterred to medical			2	Place of Dea	1 ☐ Yes th (Check only or		′es 2□No
	O B	eyaminer?	Hospital: 1 X Inpatien	t 2 ER/Outpatio	Other			lence 6 Other (S	ipecify)
Phys ar this eral di		27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Injury a	it		now injury occurred	, see,
Attending r death. sctor: After by the fune	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Yeer) Injury		s 2 🗆 No			
after des Director	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	street, factory, office		28f. Location (S City or Tow		Rural Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	dical C			examination and/or	ath occurred at the time, investigation, in my opin				
o the	Me	29b. Signature and two of certifier	3100		29c. License r	number		29d. Date signed (M	onth, Day, Year)
F 3 F 8			(		D23177	7		January 3	81 2004
0		30. Name and address of person who d	completed cause of de	ath (Item 23a) (Tyne				January 3	1, 4004
19		Mario Belledonne,			nal Lane, E	Rockvill	e. MD 20	0852	
		THE TO DETTEROURIE,	- 121 U	0.161 00010	The rest of t		,		

		1 - For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment of H tificate of L	ealth and M Death	lental Hygid	ene 2001	+ 05172
Physic	ian	Decedent's Name (First, Middle, Last)  To an	G. Levin				2. Date of Death Month	Day Year	3. Time of Death
/Medi Exami	ical	4e. Fecility Name (If not institution, give si			4b. City, Town, or	Location of Death	February	7 17 2004 4c. County of Dea	
LAum		5400 Vantage Point			Columb			Howard	
Funeral Director		217 74 9550	M 2 ★ 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y May 11,	<sup>9. Bir</sup> 1907 Mar	thplace (State or Foreign punity) Yland
land ow		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
e Mary inflied	ctor	MD Howard		Columbia					1 ☐ Yes 2 XNo
with th	DIre	10e. Street and Number	Dond		10f. Zip Code		100	. Citizen of What Co	•
na 23	Funeral Director	5400 Vantage Point	2. Was Decedent Ever	in U.S. 13. V	21044 Was Decedent of His	spanic Origin? (Spe	ecify Yes or No-	United St	erican Indian,
s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I thealth and Mental Hygiene. Itiem 27 is marked other than "natural; or items 23s or 28s-f ehow other traumatic event, the Medical Examiner must be notified at	b	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🏖 No If Yes, Give Year or Dates:		f Yes, specify Cubar 1 ☐ Yes 2XX No	Specify:	Rican, etc.)	Black, White	e, etc. White
72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	lent's Usual Occupa	luring most of worki	ng 16	6b. Kind of Business	Industry
within ene. than	Completed	Elementary/Secondary (0-12) unknown	College (1-4or 5+)	Mana	00 NOT use retired) Ger	)		Pharmacy	
e filed I Hygi other	a	17. Father's Name (First, Middle, Last)			<u> </u>	18. Mother's Name			
y can build by Menta Arked aric e	To B	Joseph Bass				Mary Bucl			
d 2 sh d 2 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Typ						City or Town, State, I	
s 1 and f Heall item 2 other	-	Judith Kline/Daught 20a. Method of Disposition	20	b. Place of Dispo	DOVER COU sition (Name of natory or other place			land 2104 c. Location - City or	
Page:		1 ☑Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State	Beth El			-2004 B	altimore,	MD
permit. Pages 1 and 2 should be filled within permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other traumatic event, the Mea		21. Signature of Funeral Service License	( ) 11 ()						ily FH Inc. , MD 21043
NA SE		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that raused the eacause on each line.	deeth. Do not ente	er the mode of dying	g, such as cardiac c	or respiratory arrest	t,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Reus	ul 1~	Suffic	iency			Onsor and Dogan
Examiner			Due to (or as a cor	efel	Mell:	120			
P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	rsequence of):	e -	+			
xecute and il-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a con	sequence of):	iS				,
cate be executed physicien and the burial-transit	dlcal E	L <sub>d</sub>							
		IF FEMALE:							
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	ic. If yes, outcome of print 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	· · · · · · · · · · · · · · · · · · ·		23d. Date of del Month	ivery Day Year
that the	by Ph	Part II. Other significant conditions conf	ributing to death but not	t resulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
w requires been sign should be		Dyspage	ris				1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
e law re has be	Completed	Prevenel	Azote	znu's			24a. Was an autopsy	prior to	itopsy findings available completion of cause of
vician: The certificate h rector, page							performe 1 ☐ Yes 3€	d? death? ]No 1 ☐ Yes	5₹ No
ding Physician: The lar h. After this certificate has funeral director, page 2	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	2 ER/Outpatien	t 3 DOA Othe	26. Place of Death		ce 6 □Other (Spe	cifu)
ding Phy After this funeral o	T:U	27. Manner of Death	28a. Date of Injury (Month, Day Yee	28b. Time of			28d. Describe how		Sily)
tendir leath. tor: Af	catle	Natural 5 ☐ Pending     Accident investigation     S ☐ Suicide 6 ☐ Could not be			M 1 🗆 Y	′es 2 □No			
ital or At irs after d ral Direct	Certification;	4  Homicide determined	28e. Place of Injury building, etc. (Sp.	pecify)			City or Town,		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, I	edical	one) 2 Medicel Examin	er: On the best of my er: On the basis of exar and manner stated.	knowledge, death mination and/or inv	estigation, in my op	inion, death occurre	ed at the time, date	and place, and due	to the cause(s)
To To Corr	Σ	29b. Signature and title of certifier		. ^	29c. License	number		Date signed (Monti	
Λ		30. Name and address of person who cor	noleted cause of death	(Item 23a) (Type	Print)	424	F'e	ebruary 1	8, 2004
'		Willie B. MVEU	4BAMD	10 to	monh	Deather	AV Cot	ancille	UD 2128
St Regis	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	south				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05173 For State Regis Certificate of Death Reg. No 2. Date of Death 1997 Physician /Medical 4c. County of Deal streerand number) **Examiner** Year If Under 24 Hrs. hplace (State or Fereign If Under 1 Age Anyrs. last birthday) **Funeral** Days Hours 1.2M 2□ F Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. 10b. Cou or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Be Completed by Funeral Director 10g. Citizen of What/County? 10f. Zin Code 10e. or iteme 23a Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian. Marital Status Black, White of 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced "natural". 16a. Decedent's Usual Occupation (Give lying of work done during most of working life. DO 100 Puse petired) 15. Decedent's Education (Specify only highest grade completed al Hygiene. 18. Mothe permit. Pages 1 and 2 should be t Department of Health and Mental I Important: If Item 27 is marked of any injury or other traumatic eve Mental 2 Baltimore, 20a. Method of Disposition ☐ Burial 2. Cremation 3 Removal from State ⁴ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. 5 ter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit 0 Due to (or as a consequence of Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificate has autopsy 1 Yes Division of Vital To the Hospital or Attending Physician: 26. Place of Death (Check only one, After this certific funeral director, 25. Was case referred to medical examiner? Be Hospital: Other: 2 Yes 2 🗆 No 1 Inpatient 2 Z ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; Natural 5 Pending 2 🗆 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FFB1

9 2004

32. Registrar's Signature

ì		•	1 - For State Registrar	State of Marylan	d / Department of F Certificate of	Health and M Death	ental Hygiene Reg. No	2004	05174
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici /Medic		DIANE		LAW	ISON 5	February Da	15, 2004	15,35 M
	Examin		4a. Facility Name (If not institution, give s The Johns hof	kins hosfit	1 R-11.	or Location of Death	. V	. County of Death	
	Funeral Director	2	5. Social Security Number 6. Sex 14-64-016 1	7. Age (In yrs.	Ast birthday) If Under 1 Year Months Days		8. Date of Birth (Moeth, Day, Year)	5 Mar	place (State or Foreign htry)
	Maryland f show	ŏ	10a. State 10b. County	10c. City	7. Town or Location	5		1	0d. Inside City Limits  Yes 2 □ No
	with the Pa or 28s-	Direct	10e. Street and Number	and Coffee	10f. Zip Code	112	10g. Ci	tizen of What Coun	ntry?
	er death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of I	Hispanic Origin? (Spetan, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amend Black, White,	
215-0036	72 hours after death with the Maryland natural', or itams 23a or 28a-f show Jical Exaciliat must be indiffed at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 📉 o		10- 1	Specify:B/	ack
1215-		Completed	15. Decedent's Edu (Specify only highest grade Elementary/Sedondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done ife. DO NOT use retire	during most of working		Cind of Business/Ind	luce 0 -
nd 2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ine Me	Be Co	17. Father's Name (First, Middle, Last)	_	W 27101	18. Mother's Name	(First, Middle, Maider	1 Sumame)	yur saes
Maryland	should I ind Meni i marke umatic	₽(	maries k. Wi	en Print	10h Mailine Address (Street	Edna	BOOZ	Rayon State Zie	Code
, Mai	ss 1 and 2 st of Health and item 27 Is n r other traun	7	19a. Informant's Name/Relationship (Ty, DayNa Wilkers	on Daughter	19b. Mailing Address (Street) 3 Ambo (	Brde J	Balto-M	10 Q12	20
ore	ges 1 t of He If iter or oth		20a. Method of Disposition  Surial 2 Cremation 3 R	emoval from State	lace of Disposition (Name of emetery, crematory or other pla	ce) 2 2	20/04 D	ocation - City or To	own, State
Baltimor	Line Pa		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>		Shell & Memoria	assort Facility	- Da	140 WI	21244
Ba	permit. Departr Imports any inji		1/4-	11 - Shower	Vaugha	Corper (	Fruero	MODE	15ces
E	, A :	ij	23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	ations that caused the death	n. Do not enter the mode of dyi	ng such as cardiac or	respiratory arrest,	1-10-04 6	Approximate Interval Between
) is	Physician		Immediate Cause (Final disease or condition	CARDI	Λ				Onset and Death
*	/Medical Examiner		resulting in death)	Due to (or as a consequence of the CORONA		24 DISE	ASE		5 YEARS
4,	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of the consequence of t					ZOYEARS
o,	ate be executed only sician and the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a consequ					
8760	icate be ex physician s the buria	dical		l					
9		/Med	IF FEMALE: 2	3c. If yes, outcome of pregna	ncv			23d. Date of delive	
P.O. Box	requires that the death certific seen signed by the attending p hould be detached for use as	Completed by Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown		у		Month	Day Year
	s that med by e deta	y Pt	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the underlying cause given	ven in Part I.		use contribute to th	ne cause of death?
ord	w require been sig should b	ted t	DIABETES				1 🗆 Yes 2	No 3 Prob	ably 4 □Unknown
of Vital Records,	The law ate has t page 2 s	comple					24a. Was an autopsy performed?	death?	psy findings available inpletion of cause of a No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	1		26. Place of Death	(Check only one)		
of	Physical this cal dire	2	1 ☐ Yes 2 ☑ No  27. Manner of Death		Ervoulpatient 3 DOA		ne 5 Residence 8d. Describe how injur		"
ion	ath. r: After	ation	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury Wo	rk?  Yes 2   No	ad. Describe flow injul	y occurred	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, office	2	8f. Location (Street ar City or Town, State		l Route Number,
	e Hospit 24 hours e Funers letely fille	Medical (	29a. Certifier 1 ☐ Certifying Phys (Check only one) 1 ☐ Certifying Phys 2 ☐ Medicel Examin	sician: To the best of my kno ner: On the basis of examinal and manner stated.	wledge, death occurred at the tition and/or investigation, in my o	me, date and place, a opinion, death occurre	nd due to the cause(s d at the time, date and	) and manner as st d place, and due to	ated. the cause(s)
	To th Within To th compl	Me	29b. Signature and title of certifier	0.0	29c. Licens		29d. Da	te signed (Month, L	Day, Year)
	2.	4	NO	> VN >	RE 123a) (Type, Print) Teet Johns Hap	5-000	Febr	VERY 15	, 2004
	1/		30. Name and address of person who co	mpleted cause of death (Item North Wolfe St	Teet Johns Hope	kins Hospit	al Baltim	lore, MD	21287
e est	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa					

04-1076 B.K.S JOHN LEWIS

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Fu	hysicia /Medic Examin	an	1. Decedent's Name (First, Middle, La								05175
Fu	/Medic	all		st)				2. Date of Dea Month	Day	Year	3. Time of Death
Fu	Examin	al	John A. Lewis			1 0 T	1	FEB.	7, 20		1035 A M
		er	4a. Facility Name (If not institution, giv 616 NORTH BOULDI				Location of Death		4c. Cc	ounty of Death	
	ineral		5. Social Security Number 6. S	Sex 7. As	ge (In yrs. last birthday	) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h Voosl	9. Birthp	place (State or Foreign
Dir	ector		214-62-7545	M 2□ F	49 Yrs.	Months Days	Hours Min.	Apr 16	1954	4 Cour	unk unk
pue	*2		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				1	0d. Inside City Limits
Manyla	f sho	ō	MD			Baltimo	re				1X Yes 2 □ No
the	r 28a	rec	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Cour	ntry?
th with	23a o	alD	616 N. Bouldin	Street		2	21205			USA	
1215-0036 within 72 hours after death with the Maryland ene.	tems BECOM	Funeral Director	11. Marital Status unk	12. Was Decedent Armed Forces	,	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
36 rs afte	, or	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dates:	No unk	1 ☐ Yes 2 🗓 No	Specify:		Sp	pecify: b1	ack
2 hou	atura cal E	ted	15. Decedent's E	ducation	16a. Dec	edent's Usual Occupa	ation	unk	16b. Kind	of Business/In	dustry 1-21-
2157 Brin 7:	u. W	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or	life.	e kind of work done of DO NOT use retired	during most of work 1)	ding dirk			unk
Ngen ya	t, the	Соп		nk		1					
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Menial Hygiene.	even	Be	17. Father's Name (First, Middle, Last,	)		unk	18. Mother's Nam	e (First, Middle,	Maiden Su	imame)	unk
should nd Mer	marke	ို	19a. Informant's Name/Relationship (	Type Print)	unk 19h Mai	ing Address (Street a	and Number or Rus	a / Route Numbe	or City or Ti	own State Zin	Code
Maand 2 s	27 la r trau		Total mornial to the morning of	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	CITIC 100. May	mg / (ddi ooo   oii oo)	and training of the	arriodio rompo	ii, Oily Gr	own, otato, zip	unl
altimore,	othe		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other plac	e)	Date	20c. Locat	tion - City or To	own, State
Pages	unt: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 🕅 Other (Specil	]Removal from State y) <b>in</b> s <b>tat</b> e							
Balt permit. Departr	Important: if item 27 Is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner coast be notified at once.		21. Signature of Fune, I Service Licer Ronald S.	Wade, bir		2. Name and Address tate Anato altimore,		1655 W.	Balt:	imore S	treet
ų,			23a. Part. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death. Do not er						Approximate Interval Between
Phys	sician		Immediate Cause (Final disease or condition		sclerotic	Cardiovas	cular Dis	sease			Onset and Death
/Me	edical		resulting in death)	_ a	a consequence of):						
Exan	Examiner		Sequentially list conditions,	b							
pe,	sit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	à consequence of).						
) axecut	physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
8760,	/siciar e buri	dical		d						i	
68 rifficat	ට ශ්		15.55111.5								
Records, P.O. Box 68760, The law requires that the death certificate be executed	ed by the attending p detached for use as f	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	2 Fetal death 3	□Ectopic pregnancy			23d	I. Date of delive	Day Year
D. E	the at hed fo	/sici	1 Yes 2 No	4□Pregnant a 9□ Unknown	t time of death 5	Other (specify)				MORE	Day rear
P.O.	ed by detac	Phy	Part II. Other significant conditions of	contributing to death i	out not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use	contribute to th	ne cause of death?
ds,	200	d by			,	, , , , , , , , , , , , , , , , , , ,					ably 4 Unknown
COL	s peen s	Completed						24e. Was :	an 2	4b. Were auto	psy findings available
Re la	ate has	ошь						autop	sy med? 2 <b>X</b> No	prior to cor death? 1  Yes	npletion of cause of
ital	certificate rector, pag	a	25. Was case referred to medical				26. Place of Deat			1 1 105	2010
f V	Ø ⊕	To B	examiner? XXYes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatie	ont 3□ DOA Othe	er: 4 🗌 Nursing Ho	ome 5 🗆 Resid	ence 6 X	Other (Specify	AT SCENE
Vision of Vita Attending Physician:	- 10	:uo	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ly Year) Injury	Work	(?	28d. Describe h	ow injury o	ccurred	
SiO Itend	tor: A	cati	2 Accident investigation 3 Suicide 6 Could not b				Yes 2 □No	204	V4141		
<b>☆</b> 5 € 6	<u>a</u> =	Certification:	4 Homicide determined	286. Place of in	jury - At home, farm, s tc. <i>(Specify)</i>	reet, factory, office		City or Tow		iumber or Hura	l Route Number,
To the Hospital or within 24 hours after	To the Funerel Director: Atter completely filled in by the funer				of my knowledge, dea of examination and/or i						
the thin 2	mplet	Medical	29b. Signature and title of certifier	and manner st	ated.	29c. License				igned (Month, i	
7 2 5	ř 8			m >		0.C.	M.E	"	FEE	-	2004
			30. Name and address of person who	completed cause of		Print) Street,	Baltimor	e, Maryl	land 2	21201	
A.	Sta	te		32. Regist							
R	Registr	ar	31. Date filed (Month, Day, Year) FEB 1 9 20	104 1000	S B A	MALL!					

			Sor State Registrar AMEND ITEM #10g	tate of Maryland PER FH G828 2/15	-				iene 2001	+ 05176
			Decedent's Name (First, Middle, Last)		-			2. Date of Deat Month	h Day Yeer	3. Time of Death
П	Phýsicia /Medic		WILLIAM LIJINS	KY				EB	16 200	4 9:49AM.
-	Examin		4a. Facility Neme (If not institution, give stre	et and number)		4b. City, Town, or Loc	cation of Death		4c. County of Deat	h <sup>'</sup>
				ENERALL	tosp.		Under 24 Hrs.	1	HOW	11
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	Yrs.		lours Min.	8. Date of Birth (Month, Day, OCT 19,	1928 I Sint Co	hplace (State or Foreign untry) RELAND
	Director	-	548-46-1747 X** Usual Residence of Decedent	/ 5				001 19,	1920 1	KELAND
	yland	Ì	10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	Mar-fal-	ģ	MD HOWARD	C	OLUMBI	Α				1 No 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Go	
	23a	E E	11398 HIGH HAY DR.			21044				RITIAN
036	be filed within 72 hours after death with the Maryland ntal Hygiene.  Identify then "netural", or flems 23a or 28a-f show event, the Medical Examiner must be nutified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Λ Year or Dates:	If	as Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Spe Mexican, Puerto I pecify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
Š.	72 ho	Completed	15. Decedent's Educati (Specify only highest grade co		16a. Decede	ent's Usual Occupation ind of work done durin	n na most of workii	na l	16b. Kind of Business/	Industry
2	within lene.	nple		College (1:4or 5+)	life. D	ONOT use retired)			MEDICA	1
12	filed w Hygier other th		17. Father's Name (First, Middle, Last)	J1				(First Middle I	Maiden Sumame)	
Maryland 21215-0036	should be find Mental Hammarked or umatic ever	To Be	MOSHE	1	LIJINS			ECCA		RSHMAN
lan	SPEE		19a. Informant's Name/Relationship (Type,	´_ <b>\</b>		,			City or Town, State, 2	Zip Code)
	s 1 and 2 of Health a item 27 is other trai			(IFE)		HIGH HAY			MD 21044 20c. Location · City or	Town State
Baltimore,	it of H it it		20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	oval from State cen	netery, crem	atory or other place) SERV. CORP.	1		TOWSON, MD	Town, State
單	rt. Pa rrtmer rrtent njury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature Juneral Service Licenses</li> </ul>	niti					ON & BROS.	, INC.
Ba	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		> scott M a	attle					SVILLE, MD	21208
Н	₹		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the death.	Do not ente	r the mode of dying, su	uch as cardiac o	r respiratory arri	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Seps	Sis					6 days
В	/Medical Examiner		resulting in death)	Due to (or as a conseque	nce of):	- 1 10				
Ы		-	Sequentially list conditions, b	Due to (or as a conseque	nce of):	mkita	no			days
	nted insit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,	U				
Ć,	be executed ician and burial-transi	Examiner	that initiated events c resulting in death) Last	Due to (or as a conseque	nce of):					
8760	cate be executed physician and the burial-transit	dicai	<b>L</b> d							,
9	n certifica anding ph use as th	Ned	IF FEMALE:		-					
). Box	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq Yes \) 2 \( \subseteq No \)	If yes, outcome of pregnand  1 Live birth 2 Fetal d  4 Pregnant at time of dea  9 Unknown	eath 3 1	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
P.0	hat thu d by t fetach	Phy	9 ☐ Unknown  Part II. Other significant conditions contril	nuting to death but not result	ing in the up	deriving cause given in	Part I	23a. Did tol	pacco use contribute to	the cause of death?
Vital Records,	quires tha n signed ald be del	d by	Pheymonia C	diff we	1/3	Stapa.			es 2□No 3187Pr	
000	aw requir is been s 2 should	Completed	bailerenna, e	interococ	cal	UTI		24a. Was a	n 24b. Were au	itopsy findings available completion of cause of
R	0 - 0	E	Arobe renal 1	ashire d	166.	etes mé	le Dos	perforr	ned? death? 2⊠No 1 ☐ Yes	
ita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				. Place of Death	(Check only on	θ)	
of V	8 8	2	1 ☐ Yes 2 € No	inpatient 2 E	R/Outpatient	The second second			ence 6 Other (Spe	cify)
on c	ding Phy th. After thi funeral of	<u></u>	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes	2 □ No	28d. Describe no	ow injury occurred	
isic	ttendir death. ctor: Ai y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	e farm stre		_	P8f Location (SI	reet and Number or Ru	ural Route Number.
Division	i or Attend after death Director: , d in by the f	ertification;	4 Homicide determined	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	ot, radiory, office		City or Town		
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C		an: To the best of my knowl						
	inhin i	Mec	29b. Signature and title of certifier	and manner stated.		29c. License nu	ımber	2	9d. Date signed (Mont	h, Day, Year)
	F ¥ F 8		1 A I M	CP		D 268	345	Ī	Eb 16	2004
	20		30. Name and address of person who come	oleted cause of death (Item 2	23a) (Type, F	Print) MAI _ /	ati NI	GIAVE	1 (IM) E	=CCP
	")"		30. Name and address of person who comp	i Coli	144	in	10 21	044	0,000	
	Sta	ite	31. Date filed (Month, Day, Year) FEB I 9 2004	2. Registrar's Signatu	re A	W x		* Ŧ		
12.	Registr	ar	FED 1 3 2004	JOHNAN DE	MARIAN					

State of Maryland / Department of Health and Mental Hygiene 2004 05177 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dey Mckn (614 15:20 AM **Physician** MARIAN FCB 12 2204 /Medical 4c. County of Deeth 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 18, 1 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Sociel Security Number **Funeral** 1□M 2XF 1923 Washington, DC 80 579-24-1351 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10b. County rthen "natural", or items 23e or 28a-f shov the Madical Examiner rount be notified at 1 ☐ Yes 2 ☑ No **Funeral Director** Chevy Chase Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4521 East-West Highway; Apt. 312 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specity: African-Baltimore, Maryland 21215-0036 à 3 V Widowed 4 □ Divorced American Completed 16a Decedent's Usual Decupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Resident Manager County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard Bryce Eleanor Tyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is eny injury or other trai once. 4919 Strathmore Ave; Kensington, MD 20895 Earl William McKnight, Sr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Loudon Park Crematory 02/16/2004 Baltimore, MD 21. Signal of Funeral Service Lice 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center Unlly 1040 Rockville Pike; Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. myelogenous Levenin Immediate Cause (Final Acuta 4 Wints **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical as the l IF FEMALE: Box 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 0 in the past 12,months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Ö 9 Unknown been signed by should be detac ٦ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown accident Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe page 2 s has certificate 1 Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ✓ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No o After this 28a. Date of Injury (Month, Day Yeer) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Division Natural 5 Pending or Attandin after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cer D29675 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6420 Rocklep66 Dr Beaker Dr LINGH BOLLIA my 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

MANAHAM

# **VOID**

# CERTIFICATE #

04-05/18

# SEE

# **CERTIFICATE #**

03-44/36

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** Month Matthews Joseph 5:03 PM Februar /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death-4c. County of Death Examiner Center Baltimore VA Medical Baltimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Y 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours 47-52-2708 Usual Residence of Decedent 1 M 2 □ F Director out permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Ses 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1811 1216 nomas Q 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Mo Specify: þ 3 Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 17. Father's Name (First, Middle, Last, 18. Mother's Name (First Midd Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seph D · M Method of Disposition Bato MD 2 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State emeter 21. Signature of Funeral Service Licensee rat Services 23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours eigher death.

To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the inneral director, page 2 should be deteched for use as the burlet-irest Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deeth 1 Natural 2 Accident Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 2 No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 29b. Signature and title of certifie

31. Date fied (Month, Day, Year)

FEB

of person who completed ca

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32 Registrar's Signature

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30. Name and address

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se of death (Item 23e) (Type, Print)

Greene

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 05180 For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** FEBRUARY 8:15 P. 16, CHARLES Η. MULLER 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PARKVILLE 1805 YAKONA AVENUE BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 1/24/1922 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 M 2 □ F 214-14-7093 82 MARYLAND Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 10h County 1 ☐ Yes 2 ☑ No **Funeral Director** BALTIMORE PARKVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1805 YAKONA AVENUE 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐XYes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) LOCK-RETAIL SALESMAN 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FREDERICK MULLER VIRGIE DAUGHTERY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTIMORE, MD WIFE 1805 YAKONA AVENUE CHARLOTTE V. MULLER 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Dogation 5 Other (Specify) METRO CREMATORY, INC. 2/18/2004 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOUNSCACAR ATTHOROSCUROTIC Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Certification; To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Yea in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 1 Yes 20 No 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contin who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Withrothe 88/3 WACTHALWOODS MICHARL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinant must be notified at once.

**Physician** 

/Medical

**Examiner** 

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page 2 should be

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The law requires that the death certificate be executed

or Attending

death.

within 24 hours after death To the Funeral Director:

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene 2 05181 State Registrar AMEND ITEM #1 PER PHY G828 2/19/04 Contificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2004 ROBERT MALLETTE Fer WALLOW C. POBERT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) March 6,1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F 366-22-6300 Michigan Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 € No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 6109 Burnt Oak Road U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite eny injury or othar traumatic event. It a Medical Examina 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ng most of working Elementary/Secondary (0-12) College (1-4or 5+) Credit Manager CSX Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilfred Mallette Marion Sylvester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6109 Burnt Oak Road Catonsville, MD 21228 Merrilyn Mallette (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Memorial 4 ☐ Donation 5 ☐ Other (Specify) 2-14-2004 Sykesville, Maryland 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner neumonic Sequentially list conditions, if any, leading to immediate cause Er technology Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, the attending physician hed for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?] þ Division of Vital Records. 440nknown 1 ☐ Yes 2 ☐ No 3 Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 1No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 1 ☐ Yes É No 3□ DOA Medical Certification: To 2 ER/Outpatient this filled in by the funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 24 hours a 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 1072 MI) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) OO Month **Physician** 2004 30173171 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. ollo 5. Social Security Number 6. Sex ontameri If Under 1 Year 8. Date of Birth (Month, Day, Year) Birtholace (State or Foleign Country)
 unk 7. Age (In yrs. last birthday) **Funeral** Days Hours Months | 1 □ M 2 🛛 F 577-42-3538 Yrs. 93 Sept 1, Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: If item 27 is merked other then "natural", or items 23a or 28a-1 show amy injury or other traumatic event, the Medical Evaninat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Silver Spring Montgomery 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 2601 Bel Pre Road 20906 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Lest) unk 18. Mother's Name (First, Middle, Maiden Surneme) unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Millenium Bel Pre 2601 Bel Pre Road Silver Spring, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donetion 5 🖔 Other (Specify) in state State anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee Ronald S. Wade, Director Baltimore, MD Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final Atherosclerofic Candoroscular disease or condition resulting in death) Examiner Physician/Medicai Examine attending physician end for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) signed by the a Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? been sig 24a. Was an autopsy performed? Completed certificate has b lirector, page 2 s 1 Tes 1 ☐ Yes 2 ☐ 60 lo To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X ursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the course of the cause (s). 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29d. Date signed (Month, Day, Year)

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State Registrar

29h. Signature and title of pertifier

31. Date filed (Month, Day, Year)

751

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

New

FEB 1 9 2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05183 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month Year **Physician** February 12, 2004 5:30AM Henrietta В. Nechin /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Rockville Montgomery Hebrew Home of Greater Washington If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Hours 1 □ M 2 🗓 F Months Director June 19,1918 New York 055-14-4707 Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours after death with the Marylend nent of Heelth and Mentel Hygiene. Interest of tems 23e or 28e-f show int: If Item 27 is marked other than "natural, or items 23e or 28e-f show 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County traumatic event, the Medical Examiner must be notified a 1 ☐ Yes 2 X No Directo Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 15107 Interlachen Drive by Funeral 20906 United States 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Be Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Harry Bettinger Rose Weintraub 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Relationship (Type, Print) Depertment of Heelth important: if item 27 Herbert Nechin/Spouse 15107 Interlachen Drive; Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State 2/18/04 Baltimore, MD 4 □ Donation 5 □ Other (Specify) Loudon Park Crematory 21. Signature of Funeral Service Licenses Sample of Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner use es the buriel-trensit Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) end Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peugis Be Completed by ate has been signe page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 34 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral o 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death s after de-rai Director: Afte 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 5 To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certific 2004 M rson who completed cause of deeth (Item 23e) (Type, Print) Montrose Rd Rockville

DHMH 16 Rev 6/95

State Registrar

PTON MD 32. Restrar's Signature

			1- State of Maryland State of Maryland Registrar	Department of I Certificate of	Health and M Death		ene 2004	05181
	Physic	ian	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medi		RONALD E. NOVAK			FEBRUARY		6:55 A.M
	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	or Location of Death		4c. County of Death	
		3 -	GILCHRIST CENTER	TOWSO	N		BALTIMOR	Æ
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia	st birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1	9. Birth	place (State or Foreign intry)
ĝ	Director		213-32-5977 <sup>1</sup> × M 2 F 67	Yrs.	110013	2/22/19	36 MAF	RYLAND
	pu 💃		Usual Residence of Decedent  10a. State 10b. County 10c. City	Town and annual				
	aryla sho	2		Town or Location				10d. Inside City Limits
	88-1-88	cto	- January OVB	RLEA				1 ☐ Yes 2 No
	or 2	Director	10e. Street and Number	10f. Zip Code		109	g. Citizen of What Cou	ntry?
	123a		5693 UTRECHT ROAD	2120	5		USA	
	IIIU X IX I 3-UU30 be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23a or 28a-1 show event, the Medical Exatta at rust be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	13. Was Decedent of H	dispanic Origin? (Specan, Mexican, Puerto F	cify Yes or No-	14. Race - Ameri Black, White	
9	s afte		1 Never Married 2 Married 17 Yes 2 No	1 ☐ Yes 2 ☐ No	Specify:			etc.
Š	ural Doug	d by	Year or Dates: KOREA				Specify: WHI	TE
21215_0026	72 nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	oation during most of workin	16	6b. Kind of Business/Ir	dustry
ç	withir than	m	Elementary/Secondary (0-12) College (1-4or 5+)					
	IG A e filed v Il Hygie other t		10TH GRADE	MACHINIST INS			ROWN CORK	& SEAL
Š	yiana z ould be filed Mental Hygi arked othar atic event, i	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Ma	iden Sumame)	
2	Z should by and Menta ls marked aumatic ev	2	ADAM NOVAK		BERTHA I			
Mondage	Mal yie d 2 should th and Mer 7 is marke traumatic	1 6	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street	and Number or Rural	Route Number, C	City or Town, State, Zip	Code)
	C 7 7 1		LARRY A. NOVAK SON	8334 LOCH HAY		TOWSON.	MD 21286	
č	Pages 1 nent of H int: If its		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Removal from State  20b. Placent	ce of Disposition (Name of letery, crematory or other place	Da	ate 20	c. Location - City or T	own, State
<u>.</u>	Pag ment ant: ury o		_	IMORE NATL. CE	EM. 2/23/2	2004 B	ALTIMORE,	Mir
- C	permit. Pages permit. Pages Department of Minportant: If ite any injury or of once.		21. Signature of Funeral Service Licensee	22. Name and Addre	ss of Facility THE	JOHNSON	FUNERAL H	OMF PA
				8521 LOCH	RAVEN BLVI	D. TOWS	ON, MD 21	286
			Part I. Enter the disease, or complications that caused the death. shock, or heart failure. List golf one cause on each line.					Approximate
	Physician		Immediate Cause (Final	resser	/ \	nente		Interval Between Onset and Death
	/Medical	1	disease or condition resulting in death)  Due to (or as a conseque		- Jen	700		years
SAM	Examiner							U
15		er	if any, leading to immediate Due to (or as a consequent	nce of):				
in	uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
9	exec n and ial-tra	Exa	resulting in death) Last  Due to (or as a consequence)	nce of):				
7.92	sicia bur	a						
had had	gorgo,	edlcal	d					
1	eath certificate be executed attending physician and for use as the burial-transit	Š	IF FEMALE: 23c. If yes, outcome of pregnance	,				
Box	requires that the death cert requires that the death cert een signed by the attendin hould be detached for use.	by Physiclan/M	in the past 12 months?	ath 3 Ectopic pregnancy			23d. Date of delive	ery Day Year
C	the d	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of deat 9 ☐ Unknown 9 ☐ Unknown	h 5 Other (specify)				,
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7 %	requires tha been signed should be det	d b	Ducumonia	ig in the discontining cause give	on ner aiti.		\ /	
3	v requ been shoulk	etec				1 Yes	2 No 3 Prob	ably 4 Dunknown
Novak Rov Division of Vital Rec		Completed				24a. Was an autopsy	24b. Were auto	psy findings available appletion of cause of
	ilcian: The lav certificate has rector, page 2	Co				performed	⊅? death?	
-==	cian ertifi sctor	Be	25. Was case referred to medical examiner?		26. Place of Death (			
$\pm$ $\leq$	Physi this c	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EF	Outpatient 3□ DOA Othe	er: 4 🗆 Nursing Home	e 5 ☐ Residence	e 6 Oth Specify	TICE
	ng P	on:	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28	b. Time of 28c. Injury Work		d. Describe how i		
2 0	Attanding r death. actor: After by the fune	Certification:	2 Accident investigation		Yes 2□No			
7	r Att	Ę	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28	f. Location (Stree City or Town, S	t and Number or Rura	Route Number,
	rs aff	Cer	, , , , , , , , , , , , , , , , , , , ,			Ony or TOWN, 3	tate)	
x (.	Hospital or 14 hours afte Funaral Diri tely filled in I	cal	29a. Certifier (Check only)  Certifying Physician: To the best of my knowled (Check only)	dge, death occurred at the tim	e, date and place, and	d due to the cause	e(s) and manner as st	ated.
H	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has ompletely filled in by the funeral director, page 2	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my op	binion, death occurred	at the time, date	and place, and due to	the cause(s)
2	To t To t	Σ	29b. Signature and title of certifier	29c. License	number	29d.	Date signed (Month, L	Day, Year)
			I Strothan dile	us Das	205	Fe	brume	7, 20nx
	XI		30. Name and address perso who completed cause of death (light 23	a) (Type, Print)	-		to and	
- 3-	- Ç I		60 A - R. Lee 6 6mc/ 6	701 N. Ch	arles Si	+ Bal	to ond	5150x
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature					
	Registra	ar	FEB 1 9 2004 Signer 18	And I				

		For State	State of Maryland	d / Departme <i>Certifica</i>	ent of Health and N ate of Death		ene 2004	05185
Physical Disconnection	H	Registrar  1. Decedent's Name (First, Middle, La.	501:0	00/11/100		2. Date of Death	Day Year	3. Time of Death
Physicia /Medic	al	4a. Fecility Name (If not institution, give	JUTIS	t 4b Ci	ty, Town, or Location of Death	Februar	4c. County of Deatl	
Examin	er	100 1 1	ural Hospita		altimore		,	
Funeral Director		5. Social Seculrity Number 6. S 25-52-7752		Yrs. If Uni Month	der 1 Year   If Under 24 Hrs. ns Days Hours Min.	8. Date of Birth (Nonth, Da)	Year) 9. Birth Co.	nplace (State or Foreign unity) Un Carolina
yland		Usual Residence of Decedent  10a. State 10b. County	10c. City	Town or Location				10d. Inside City Limits
ne Mar 8e-f st	ector	MD	Ba	ltimore	ي	10	g. Citizen of What Co	12 Yes 2 □ No
with th	by Funeral Director	10e. Street and Number	tale Boad	2,	Zip Code	10	ISA	umyı
r death	unera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. Was De If Yes, s	cedent of Hispanic Origin? (Sp pecify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
5-0036 72 hours after death with the Maryland natural; or items 23s or 28s-f show dical Examina in ust be natified at	by F	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 ☐ Yes 2 ∰No If Yes, Give Year or Dates:	1 ☐ Yes	S 20 No Specify:		Specify $B/$	ack
21215-0036 ad within 72 hours atl gjenen crithan "netural", or trithan "netural", or	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Decedent's U	sual Occupation work done during most of work Tuse retired)	king	6b. Kind of Business/I	ndustry
d 2121 d 2121 filed within Hygiene. ither then ant, the Mer	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Custo	dian		Hotel	
ind ind interpretation	Be	17. Father's Name (First, Middle, Last,			18. Mother's Nam	ne (First, Middle, M	aiden Sumame)	
Maryland 212- d 2 should be filed within the and Mental Hygiene. 77 is marked outs them treumatic event, the Mental treum the marked outs them the marked to be a second to to be	₽,	19a. Informant's Name/Relationship (	NS Type, Print)	19b. Mailing Addre	ess (Street and Number or Rui	rai Rovie Number,	City or Town, State, Z	ip Code)
	( -	Priscilla M.S	Uter (Doughter)	28095	ilver HillA		Oc. Location - City or	207
Datis		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □  1 □ Donation 5 □ Other (Specif	Removal from State	ace of Disposition (finetery, crematory of Memoria)	or other place)	104 F	R. Iden-MI	Nown, State
Baltimore, permit. Pages 1a Department of Hes Important: if tiem any injury or other once.		21. Signature of Funeral Service Licer		Vauc	and Address of Pacility	Fine	ral Soro	pices
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not enter the m	node of dying, such as cardiac	or respiratory arres	ot,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	· Septic &	lock				Onset and Death
/Medical Examiner			Anterior Abd		wall Decut	situs L	lleer	
pe sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ		Disease			
18760, cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):	13 1 763636			
18760, cate be exphysician at the burial	dlcal	(	d					
10 0	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar				23d. Date of deli	
S, P.O. Box (es that the death certified by the attending by the attending be delached for use a.	Physiclan/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown		c pregnancy (specify)		Month	Day Year
rds, Pquires than signed l	þ	Part II. Other significant conditions of	contributing to death but not resu	lting in the underlyin	g cause given in Part I.		accoluse contribute to	the cause of death?  obably 4 ②Onknown
Division of Vital Records, P.O. Box 6 for Attending Physician: The law requires that the death certif after death. Director: After this certificate has been signed by the attending in by the tuneral director, page 2 should be delached for use as	Completed					24a. Was an autopsy perform	ed? prior to o	topsy findings available completion of cause of
Vital Fician: Th	Be	25. Was case referred to medical examiner?	Hospital:		Other	th (Check only one		
on of Vital Reding Physician: The Ih. After this certificate his tuneral director, page	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	28c. Injury at Work?	ome 5 ☐ Resider 28d. Describe hov	ce 6 Other (Spec vinjury occurred	ufy)
Vision ( Attending I r death. ector; After	catlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	n	М	1 Yes 2 No	29f Location /Str	eet and Number or Ru	ral Route Number
Division  pital or Attendir ours after death. lenal Director: Al	Certification:	4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify	me, rarm, street, rac	tory, office	City or Town,		rai Houle Number,
Hos Funy	edical (		nysician: To the best of my knowniner: On the basis of examinational and manner stated.					
To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License number	29	d. Date signed (Month	, Day, Year)
$\rightarrow$		30. Name and address of person who	completed cause of death (Item	23a) (Type_Print)	89508		2.16.0	4
. \		catherine k	libuana L	0	maryland C	beneral	Utospit	a)
Sta Registr		31. Date filed (Month, Day, Year) FEB 1 9 200	32. Registrar's Signat	ure	,			

w.	LNER O	CCF	1 - State Unpend Item #2:		me G828 2/20/	rtificate of L	eaith and M Death			
	Physici	ian	1. Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death
N.	/Media		Wilner Occean		wl	4h Cihi Town or	Location of Death	January	8, 2004 4c. County of Deeth	1310 p <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, gir 326 Herring Cour	t street and number	91 )	Baltimo			To. County of Book	
	Funeral Director			Sex 7 1 ፟ M 2 ☐ F	Age (In yrs. last birthday, 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 5.	Year) 9. Birth	nplece (State or Foreign untry) UNK
	σ		Usual Residence of Decedent					ounc 5;	1724	
	anylan show	_	MD 10b. County		10c. City, Town or L Baltimo					10d. Inside City Limits 11 Yes 2 □ No
	Ba-f	ecto	10. 0			10f. Zip Code		10	g. Citizen of What Co	
	with t	Funeral Director	326 Herring Co	ourt		212	231		USA	,
	deeth ms 23	era	11. Marital Status	12. 1123 000000	nt Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-	14. Race - Amer	
030	72 hours atter deeth with the Maryland natural', or itams 23a or 28a-i ehow ursal Examitier rubal be motilled at	b	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 ☐ Yes 2[ If Yes, Give Year or Date:	□No Unk	1 Yes, specify Cubai	Specify:	Hican, etc.)	Specify: b	lack
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7	within ene. than	mple.	Elementary/Secondary (0-12)	College (1-4c	or 5+)	DO NOT use retired,	)			
2	Hygier Hygier Ther th	S	unk 17. Father's Name (First, Middle, Las	ınk		unk	18. Mother's Name	(First, Middle, N	faiden Surname)	unk
and	d be f	o Be	Tr. Factor 3 Harris (2 Mar, Imparo, 122)	,				,,		
Maryland	and 2 should be filed within 'salth and Mental Hygiene. n 27 is marked other than 'ner traumatic event, the Mas	2	19a. Informant's Name/Relationship O . C . M . E .	(Type, Print)	19b. Mait 111	ng Address (Street a Penn Str	nd Number or Rura eet Balt	al Route Number, timore, l	City or Town, State, Z.	ip Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23e or 28e-f show any injury or other traumatic event, the Musical Examiner must be notified at ODGE.		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Special Control of Control		ate	matory or other place	9)		Oc. Location - City or 1	
Balti	permit. Departm Importa any inju		21. Signature of Euner Service Lice	Wade, Di	rector S	2. Name and Addres tate Anato altimore,	s of Facility Dmy Board MD 2120	655 W.	Baltimore	Street
	Physician /Medical Examiner		23a. Pant. Enter the disease, or cor shock or heart failure. List only Immediate Cause (Finat disease or condition resulting in death)	Cardiac  Due to (or	as a consequence of):	ter the mode of dying	g, such as cardiae c	r respiratory arre	st,	Approximate tnterval Between Onset and Death
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8760,	certificate be executed nding physicien and use as the burial-transit	cal Exa	resulting in death) Last	Due to (or	as a consequence of):					
9	iffe as	Medi	IF FEMALE:							
C. Box	death e atter	by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		2 ☐ Fetal death 3 [ t at time of death 5 [	Ectopic pregnancy Other (specify)		<del></del>	23d. Date of deliver Month	very Day Year
2	law requires that the as been signed by the 2 should be detache	ed by Ph	Part It. Other significant conditions	contributing to death	h but not resulting in the I	inderlying cause give	on in Part I.		acco use contribute to s 2 No 3 Pro	1/
of Vital Records,	0 - 0	Completed						24a. Was an autopsy perform	24b. Were aut prior to coded? death?	topsy findings available ompletion of cause of
<u>E</u>	ysiclan: The is certificate director, pag	BeC	25. Was case reterred to medical examiner?				26. Place of Death			
× ×	Physiclan: this certific ral director.	70	1 XYes 2 □ No	Hospital: 1 ☐ Inpa			4   Nursing Ho			My At scene
Division c	Attending P r death. sctor: After toy the funera	Certification:	27. Manner of Death  1 X Naturat 5 Pending 2 Accident Investigation 3 Suicide 6 Could not		njury 28b. Time of Injury	Work	res 2 □No	28d. Describe ho		
DIX	Dir Dir		4 Homicide determined	building,	Injury - At home, farm, st etc. (Specify)			City or Town,		
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Exa	hysician: To the be iminer: On the basis and manner	est of my knowledge, deals s of examination and/or in stated.	th occurred at the time execution, in my operation, in my operation.	inion, death occurr	ed at the time, da	te and place, and due	to the cause(s)
,	with To Con	Y	29b. Signature and title of certifier	while	-Rolle	-1/5	.C.m.E.	Ĵ	d. Date signed (Month anuary 9,	2004
		ate	30. Name and address of person who all the control of the control	ICA-RO	IAK MU	) 111 Pe	enn Stree	t, Balti	more, Mary	land 21201
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State of Maryland / Department of Health and Mental Hygiene 004 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 5:37P M February 11, 2004 Anja I. Picoult /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 20, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 X F Months Director 082-42-3451 59 1944 Sweden Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28e-f show event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Rockville Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after deeth with Department of Health and Mental Hygiene. Importent: if tiem 27 ie marked other than "naterial pages. With or Items 23s 20852 United States 185 Hardy Place Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 No If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home (unk) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Oberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stanley Picoult /Spouse 185 Hardy Place; Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Loudon Park Crematory 02/17/2004 Baltimore, MD 21. Sign ture / Funeral Service License 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center with 1040 Rockville Pike; Rockville, MD 20852 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part 1. Enter the disease, or comshock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Acute Myocardial Infarction 48 Hours /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by eq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 1 Yes 2 No the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending 1 Tes 2 No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signaftere and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D58681 February 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h 9901 Medical Center Drive; Rockville, MD 20850 Jude Alexander, MD 32 Aggistrar's Signature Minde 1 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05188 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Kevin M Price FEBRUARY 15,2004 3:090 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE CITY Examiner 4c. County of Death GOOD SAMARITAN HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ★M 2 F 47 Director 213-68-3315 JAN. 28,1957 MDUsual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 23a or 28e-1 show 10d. Inside City Limits the Medical Exer discrinust be notified at MD 1 X Yes 2 □ No NA Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 605 McCabe 21212 USA Funeral death or Itams 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Pages 1 and 2 should be filed within 72 hours after Black, White, etc. 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 Yes 2 No Specify: <u>م</u> 3 ☐ Widowed 4 X Divorced natural', American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer 0 Warehouse man and Mental Hygid Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph H Chester, Sr. Mildred Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Itam 27 Is any injury or other trau once. Karen Y Price (niece) 3430 Woodstock Ave Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 DBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 02/21/04 Baltimore, MD 22. Name and Address of Facility Wylie Funeral Home, PA 21. Signature of Funeral Service Lice 638 N Gilmor Street Baltimore, MD 21217 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Saddl **Physician** Ulmonare /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 🔀 No 3 Probably 4 Unknown Completed certificate has t irector, page 2 s 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 24a. Was an autopsy performed? Division of Vital 1 Yes 2 | No Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1

Yes 2□No 1 ☐ Inpatient 2 ☐ XER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) the funeral Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospitel or Attending 5 Pending Natural after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Chack only one) To the the within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number **OCME** FEBRUARY 16, 2004 30. Name and address of person who complete): cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks 9 2004

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene 2004 05189 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Year **Physician** Daseph -eP 2004 15=20 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street end number) **Examiner** BALtimore NIA 14 mediCAL Center H Under 24 Hrs. 8. Date of Birth (Month, Dey, Ye JULY 23, If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Yeer) Days 1 M 2 □ F Yrs. Maryland 1928 215-24-2240 Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural" ~- any injury or other traumatic eventual. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No **Funeral Director** Maryland Harford Joppa 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 703 Shore Drive 21085 USA Race - American Indian, Black, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1947 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced 1951 Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Hydrolic Mechanic Air National Guard 12 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Antony Paglia Anna Marie Colletti 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marie Paglia/Wife 703 Shore Drive Joppa, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 2-18-04 Metro Crematory Inc. Baltimore, MD 22. Name and Address of Fecility
Cremation Society of MD, Inc. 21. Signature of Funeral Service Licenses Thomas Gregor

299 Frederick Road Baltim

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert lailure. List only one cause on each line. 299 Frederick Road 21228 Baltimore, MD Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical . Stage II A Non Small Cell lung cancer Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as e consequence of) P.O. Box 68760. that initieted events resulting in death) Lest Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deth 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Netural 2 Accident Injury 2 No 1 Yes ofter death. 6 Could not be determined To the Hospital or Atterview within 24 hours effer des To the Funeral Director completely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide incertifying Phyeician: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) end manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) N GREENE Street BALtimorp, MD 21201 mily 31. Date filed (Month, Day, Year) 32. Registrar's Signature 9 EB Registrar

**DHMH 16 Rev 6/95** 

State of Maryland / Department of Health and Mental Hygiene 10 1 05190 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** FEBRUARY 16, 2004 REMINGTON 9:51 A. **JOHN** CHARLES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE ST. JOSEPH HOSPITAL TOWSON If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours **Funeral** 1 ☑ M 2 ☐ F 213-36-1664 66 Director 6/9/1937 MARYLAND Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code ò USA Itema 23a 1842 LOCH SHIEL ROAD <u> 21234</u> Completed by Funeral death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: KOREA 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🗓 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical than Elementary/Secondary (0-12) College (1-4or 5+) PRESIDENT/OWNER BOOK STORES 2 YEARS other 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Health and Mental is marked JOHN TABB REMINGTON KATHRYN GREEN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health at Important: If item 27 is any injury or other traugonce. WIFE ANN PORTER REMINGTON 1842 LOCH SHIEL ROAD PARKVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State \* 4 □ Donationy 5 □ Other (Specify) METRO CREMATORY, INC. 2/18/2004 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final My coxcardal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tens 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal deal

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 Fetal death jo Month Day Year 5 Other (specify) ☐Yes 2☐No be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ¥Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tyes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 ☐ Yes 2 No 2 XER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Thomicide within 24 hours a To the Funeral I 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and fitte of certifier 29c. License number D0060541 MD 16. 2004 15x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Greene Street Paul Sack, MD Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State code) Registrar 9 2004

State of Maryland / Department of Health and Mental Hygiene 2004 05191 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 5 05 A.M -EBRUARY 18, 2014 C. ROBERSON WILLIAM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Yea.

The Days 8. Date of Birth (Month, Day, Year) SEPT. 21, 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Hours **Funeral** Min. 1 € M 2 □ F 75 Yrs. 1928 NC Director 238-36-5946 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f ahow the Medical Examiner must be notified at 1 X Yes 2 □ No MD NA BALTIMORE Direct 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number with 21218 death v 4317 MARBLEHALL ROAD 14. Race - American Indian, Black, White, etc. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Pages 1 and 2 should be filed within 72 hours after AFRICAN 1 Never Married 2 Married 1□Yes 2☐No ŏ Baltimore, Maryland 21215-0036 Specify ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: AMERICAN "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 CONSTRUCTION LABORER CONSTRUCTION and Menta! Hygi 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HENRY ROBERSON MARY YANCY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau ROBERSON (SPOUSE) ADA 4317 MARBLEHALL ROAD BALTIMORE, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 2/23/04 BALTIMORE, MD 22. Name and Address of Facility Funeral Service Licensee 21. Signature WYLIE FUNERAL HOME PA WYLIE FUNER
638 N. GILMOR STREET BALT
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTIMORE, MD Approximate Interval Between Onset and Death Immediafe Cause (Final disease or condition PNEUMONIA 2 WEEKS Physician resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No Ó 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 N 1 | Yes 2 - No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Depatient 2 ER/Outpatient 3 DOA ပ 1 ☐ Yes 2 ☐ N in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury af Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 Tes 2 No death. М 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide within 24 hours a To the Funeral [ 1 Gentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D47/23 FEBRUARY, 18, 2004 190 ninana 201 E UNIV. PKWY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH PUTHUMANA, UNION MEM. HESP. BALTHADRE, MD 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signatore State oaks Registrar 9 2004

State of Maryland / Department of Health and Mental Hygiene 2004 05192 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 11:15 P.M. February 17 2004 Louise Mary Rentz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville Charlestown Care Center Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Min. Hours 1 ☐ M 2 🗷 F Months July 17, MD Director 213**-**01-7349 96 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County , or Itame 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Catonsville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA 719 Maiden Choice Lane death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: 3 Widowed 4 Divorced White "natural" Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Private/Clothing Co. Secretary nit. Peges 1 and 2 should be filed a artment of Health and Mental Hygie ortent: if Item 27 is marked other injury or other traumatic event, it injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Davis 2 Theodore Rentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21014 Kathleen Stewart/Niece 1051 Wingate Court. Bel Air, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Pege Department of Important: if any injury or once. 4 □ Donation 5 □ Other (Specify) Balto-Wash Crematory | 02/19/2004 | Laurel, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, In 736 Edmondson Ave. Baltimore, MD 21228 de 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death brillation Immediate Cause (Final Physician 4615 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 015 2 MLN Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown s been signed by t 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 certificate 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 200No 1 Tes this s after death.
Il Director: After this od in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of Death Injury Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 T Homicide To the Hospitel within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier un D 0 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Lary 69213 31. Date filed (Month, Day Year) Registra s Signature State Registrar

		•	For State Registrar	State of Mary	land / C	Departme <i>Certifica</i>	ent of Ho ate of D	ealth and l Death	Mental Hy	giene Reg. No.	2004	05	193
1	Physici		Decedent's Name (First, Middle, Last						2. Date of De Month	Day		3. Time of	
	/Medic	al	Helen Kar			4b Cit	Town or	Location of Deat	Februar		County of Deat		5 p M
	Examin Funeral Director		4e. Fecility Name (If not institution, give University of Mary kin 5. Social Security Number 6. Se 15.	Medical 7. Age (In	Cente yrs. last bird	er Bo	altim ler 1 Year			rth ay, Year)	9. Birtl	nplace (State ountry)	
			Usual Residence of Decedent						1 0/22/	1,00			
	arylar ehow	-	10a. State 10b. County		c. City, Town	or Location						10d. Inside C	ıty Limits 2.ZNo
	28a-f	Director	MD Baltimore  10e. Street and Number	9		Caton	SVille Zip Code	9		10a. Citi	zen of Whal Co	untry?	
	3a or	0						228			II.S.A.		
136	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Itame 23a or 28a-f ehow that the Medical Examinat must be redified at	by Funeral	406 Shady Nook Av.  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S.				pecify Yes or No to Rican, etc.)		14. Race - Ame Black, White Specify: Wh	e, etc.	
1215-0036	rithin 72 horne. ne. hen "natur	Completed	15. Decedent's Edu (Specify only highest grad		16a.		work done di use retired)	uring most of wo	rking		nd of Business/	Industry	
2	filed with Hygiene other the		17. Father's Name (First, Middle, Last)			Home	emaker		me (First, Middle		n Home		
Maryland	a la b	o Be	Henry Voskuhl					Mary Co		,	,		
3	s 1 and 2 should be if Health and Menta Item 27 le marked other treumatic ev	ဥ	19a. Informant's Name/Relationship (T)	rpe, Print)	19b.	. Mailing Addre			ural Route Numb	er, City o	r Town, State, 2	lip Code)	
	1 and 2 Health a tem 27 le		Earl Ramp - Husbar		4	06 Sha	iy Noc	k AVe.	Catonsvi				
altimore,			20a. Method of Disposition  1  Burial 2 Cremation 3    4  Donation 5  Other (Specify,	removal from State		Disposition (A y, crematory o tore/Was		! .	Date 6/2004		cation - City or	Town, State	
Bait	permit. Pege Department of Important: If any injury or once.		21. Signature of Suneral Service Licens		li	22. Name	and Addres	s of Facility Wi	tzke Fur dson AVe	era1	Home o	f Cato	ns-
8760,	Physician /Medical Examiner physician and physician and physician and physician and street physician and physician	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence	ol): of):	enal	failur	e			Interval Bel Onset and	Death
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ds, P.	w requires that the de been signed by tha should be detached	þ	Part II. Other significant conditions co	ntributing to death but no		the underlyin	g cause give	n in Part I.			se contribute to		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by this completely filled in by the funeral director. page 2 should be detached.	Completed	Diabetes Melli	tus					24a. Was auto perfe 1 ☐ Yes		prior to death?	topsy findings completion of a	available ause of
/ita	cian: ertifici actor.	Be (	25. Was case referred to medical examiner?	In-retal			0		ath (Check only	one)			
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Divisi	al or Attending P s after death. Il Director: After t d in by the funera	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, la Specify)	rm, street, fact	ory, office		28l. Location ( City or To	Street an wn, State	d Number or Ru )	ral Route Nun	nber,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one)  1 ☐ Certifying Phyone 2 ☐ Medical Example	rsician: To the best of miner: On the basis of example and manner stated	amination an	dor investigati	ed at the tim on, in my op	e, date and place inion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s	5)
	To the within To the comp	M	29b. Signature and title of certifier				29c. License				e signed (Mont)		41
•	, 0		wy	MID.			P15.	834		Febr	uary 1-	5,20	004
			30. Name and address of person who of Willy Tsai 22 S.	Greene St.	Ba	(Type, Print) Hint	e, r	1D 2	1201				
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrats	Signature	he L	ast !						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 05194 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 6, 200**4 Physician** 3:55 AM M Charles Rideout /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 8, 1915 9. Birthplace (State or Foreign Country) 1111k 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1⊠M 2□F unk 88 220-10-6706 Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itsm 27 is marked other then "naturel", or items 23s or 28s-f show other treumstic event, the Medical Examinar must be notified at MD Harford 1 ☐ Yes 2 No Belcamp Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1123 Belcamp Road 21017 USA Funeral unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours efter of Heelth end Mentel Hyglene. Bm 27 is marked other then "naturel", or itel 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married unk 1 ☐ Yes 2 No Specify: white Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk Be Depertment of Heelth end M important: if Itam 27 is mar eny injury or other treumst 900s. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Upper Chesapeake Medical Center 500 Upper Chesapeake Drive Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State '4 □Donation 5 MOther (Specify) in state 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street irector Baltimore, MD 21201 23a. Part L. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician here /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gauss (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien end for use es the burial-trensit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Δ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 0 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 2 □ No deeth. 1 Yes 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) e Hospital or A 124 hours effer e Funeral Direc 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6,2 5 Dha MA UNN ev. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 1 9 2004 Registrar

32/06/04

Rideout, Charles

		_ 1	For #b State RegistrarAMFND ITEM #4a					nd Mental Hyg	iene 2 0 (	05195
	Physicia		1. Decedent's Name (First, Middle, Last)	0 10				2. Date of Deat		3. Time of Death
	/Medic	al	William	D. K	cape	4b. City, Town,	or Location of	Oa	4c. County of	04 10,37A"
1.	Examin	er	4a. Facility Name (If not institution, give		•	4b. City, Town,	12th -4	LC.	Bac	to
	Funeral		5. Social Security Number 6. Set		e (In yrs. last birthday	) If Under 1 Year		Hrs. 8. Date of Birth Min. (Month, Day,	Vear) 9	Birthplace (State or Foreign Country)
	Director		066.26.5819	M 2□F	72 Yrs.	Months Days	Hours	Min. (Month, Day,	31	New UR.
	pu &		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
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	r 28a-	rect	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	at Country?
	th with	Funeral Director	8720 Emge Road				21234	•		SA
	eme :	ner	11. Marital Status	12. Was Decedent Armed Forces?		. Was Decedent of If Yes, specify Cu	Hispanic Origi ban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)		American Indian, White, etc.
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 1 If Yes, Give Year or Dates:	No	1□ Yes 2□ No	Specify:		Specify:	black
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23a or 28a-f ehow the Madical Examiner must be motified at	ted	15. Decedent's Edu	cation	16a. Dec	edent's Usual Occu	upation	duarting	16b. Kind of Busin	ness/Industry
215	thin 7.	Completed	(Specify only highest grad	College (1-4or !	5+) life.	DO NDT use retir	ed)			
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and	I be filed ntal Hygid ed other	Be	17. Father's Name (First, Middle, Last)  Cyruk Hubert Rea	ape				ha Woodruff		
Maryland	and Menits market	ပ္	19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mai	ling Address (Stree		or Rural Route Number		ate, Zip Code)
	and 2 salth ar		Georgianna Holland,	former s	pouse P.O	. Box 114	445 Bal	timore, MD	21239	
more,	-135		20a. Method of Disposition  1 Burial 2 Cremation 3 6  4 Donation 5 Other (Specify)		20b. Place of Disposer cametery, cr	position (Name of ematory or other pi	lace)	Date	20c. Location - Ci	ty or Town, State
D	permit. Pages Department of I Importent: If its any injury or o		21. Signature of Euneral Service Licens ROYald S.	vade, Dir	ector S	22. Name and Add tate Ana altimore	ress of Facility Lomy Bo MD 2	ard 655 W. 1201	Baltimor	e Street
	-170		23a. Part 1 Enter the disease, or comp shock, or heart failure. List only o	ications that caused	the death. Do not e			ardiac or respiratory arr	est,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	· PMOSI	a consequence of):	ras				Onset and Death
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,092	te be executed ysicien and te burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of):				- TW-00	
Box 68	death certificate e attending phy ed for use as the	Pa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnan			23d. Date of	
P.O. E	0 0	Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown		Other (specify)		on- Pida-		ute to the cause of death?
	w requires th been signed should be de	by	Part II. Other significant conditions co	1 17	menting in the	underlying cause (	given in Part I.			Probably 4 Unknown
Records,	e la has	Completed						24a. Was a autop: perfor	sy price dea	re autopsy findings available or to completion of cause of ath?  Yes 2 A No
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of \	this ald	2	1 ☐ Yes 2 ☐ No 27. Magner of D ath	Hospital: 1 ☐ Inpati 28a. Date of Inji	ent 2 ER/Outpati	eni 3 DOA		sing Home 5 Resid	ence 6 Other	
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical Co			of examination and/or			place, and due to the on occurred at the time, o		
	To the vithin To the comple	Me	29b. Signature and title of certifier				nse number		29d. Date signed (	Month, Day, Year)
)	-		Martina C. 4	Munin	No	DE	54518		2/6)	04
			30. Name and address of person who o	completed cause of	death (Item 23a) (Typ			10 11727		
			31. Date filed (Month, Day, Year)	32 Rendist	(I) KOWY (I) rar's Signature	NU BOLTH	MIL IV	1021237		
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State of Maryland / Department of Health and Menta	al Hygiene
Cortificate of Death	-0.00

	1	For State Registrar	State of Mary		artment of F rtificate of			giene Reg. No.	2004	0519
		I. Decedent's Name (First, Middle, La.	st)				2. Date of De Month	ath Day	Yeer	3. Time of Death
sician edical		Francesco Raw	itch				Januar		004	745 a ™
niner		a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Dea	th	4c. Cou	inty of Death	
	J	4920-B Meridian	Way #16		Frede	erick			Freder:	ick
		5. Social Security Number $unk$ 6. S	ex 7. Age (li	yrs. last birthday, 4 Yrs.	Months Days	Hours Min		1959	9. Birthp Coun	lace (State or Foreign try) unk
	- I	Jsual Residence of Decedent								-
tor	- 1	MD 10b. County Freder		oc. City, Town or L Fre	ederick				1	0d. Inside City Limits 1 ☐ Yes 2 X No
Director	2	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	itry?
2	2	4920 Meridian Wa				21703			USA	
Filnerai	2	11. Marital Status un	12. Was Decedent Eve Armed Forces?	rin U.S.nk 13.	Was Decedent of H	fispanic Origin? (	Specify Yes or No	- 14. [	Race - Americ Black, White,	
2	2	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:	To Thours, Oto.,			white
pate	leted	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	orking unk	16b. Kind o	f Business/ind	dustry un
Completed	dillo	Elementary/Secondary (0·12) unk	College (1-4or 5+) unk	<i>m</i> 6.	DO NOT USE FEIIFE					
To Re	0	17. Father's Name (First, Middle, Last,			unk	18. Mother's Na	me (First, Middle,	Maiden Sun	name)	ur
	Ì	19a. Informant's Name/Relationship (	Typa, Print)		ing Address (Street Penn Stre		ural Route Numbe		wn, State, Zip	Code)
	-			20b. Place of Disp		tet bar	Date Date		on - City or To	Ctata
	ľ	20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  1 □ Donation 5 ② Other (Specif	Removal from State	cemetery, cre	matory or other plac					
		21. Sometrie of Funeral Service Licer	Wade, Direc	tor §	2. Name and Addre tate Anat altimore,	ss of Facility Omy Boar	d 655 W.	Balt	imore S	Street
		23a. Part1. Enter the disease, or com shack, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line.  a. Hypertens  Due to (or as a co	ive arte	101 1110 111000 01 07 11	19, 55011 45 541010	io or respiratory at	1031,		Approximate Interval Between Onset and Death
niner	in the	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c	unsaquence of):						
adical Examin	cal Exal	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
Physician/Medi	Sicializmed	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy	<i>y</i>			Date of delive Month	ry Day Year
hy Dhy		Part II. Other significant conditions of	contributing to death but n	ot resulting in the u	underlying cause giv	en in Part I.	5%		ontribute to th	e cause of death?
7	ם	Morbid obesity					18	es 2 No	3 Prob	ably 4 □Unknown
Completed	ambier					· · · · · · · · · · · · · · · · · · ·	24a. Was autop	med?	prior to con death?	osy findings available
		25. Was case referred to medical				OS Place of Do	ath (Check only o		Yes	2 No
a	٥	examiner? 1 ☑ Yes 2 ☐ No	Hospital:	2 ER/Outpatie	nt 3 DOA Oth	ac.	Home 5 Resid		Other (Essait	at scen
H	- +	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time o	of 28c. Injur	y at rk?	28d. Describe h			y ac boch
Cartification.	erilica	2 Accident investigatio 3 Suicide 6 Could not be determined	e 290 Place of Injury			Yes 2 No	28f. Location (S City or Tov		mber or Rura	l Route Number,
	edical Ce	(Check only 2 Medical Example 12	nysician: To the best of miner: On the basis of ex	amination and/or in						
Modica		one)	and manner stated		29c. Licens				ned (Month, I	
	-	29b. Signature and title of certifier			29c. Licens	o Humbel		_	nea (Monin, i 37 20 2	

State

31. Date filed (Month, Day, Year)

- LARON

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

29c. License number January 20 2004 OCME

			For State Registrar	State	of Marylan	id / Depa	artment rtificate	of H	ealth a Death	and M	ental Hyg	iene 2	004	05197
			1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici	_	R	ichard	Seward						Februar	y 16,	2004	4:30A M
)42 =	/Medic Examin		4e. Facility Name (If not institution, s	ive street and r	rumber)		4b. City, T	own, or	Location o	of Death		4c. Cou	nty of Deeth	
A			Casey House				Ro	ockv	ille			Mon	tgomer	У
	Funeral			Sex	7. Age (In yrs.	last birthday)	If Under 1 Months	Year Days	If Under:	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	Cou	place (Stete or Foreign
	Director		525-62-7713	1X M 2□F	69	Yrs.	Wiotatia	Days	7100.0		May 10,	1934	New	York
	D.		Usual Residence of Decedent		10.0	<u> </u>								Od. Inside City Limits
	irylar show	_	10a. State 10b. County		10c. Cli	ty, Town or Lo								1 ☐ Yes 2 ☐ No
	Ba-f	Director	Maryland Montgo	mery		Gait	hersbu				T			Λ
	or 28	Jre	10e. Street and Number				10f. Zip (				•	0g. Citizen	of What Cou	ntry?
	72 hours after death with the Maryland natural, or Items 23e or 28e-f show disal Examination in Miled at	la	805 Hope Court						0878			Unite		
	ems	Funeral	11. Marital Status	Armed	ecedent Ever in U Forces?	l.S. 13.	Was Decede If Yes, specif	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spe i, P <mark>uert</mark> o	icify Yes or No- Ricen, etc.)		lace - Ameri Itack, White,	
98	or In		1 Never Married 2 Married	1 Yes.	s 2 □ No Give		1 Yes 2	No No	Specify:			Spe	city: Whi	te
5-0036	ural',	Completed by	3 ☐ Widowed 4 ₹ Divorced		Dates: Kore				At a se			1Ch Kind of	Business/le	duate
7	72 h	lete	15. Decedent's (Specify only highest		d)	(Give	dent's Usuat kind of work DO NOT use	k done d	uring most	t of worki	ng	16b. Kind of	business/ir	dustry
2121	vithin Den	du	Etementary/Secondary (0-12)	College 4	(1-4or 5+)		oject					Feder	al Gov	ernment
2	fled v flygie her t		17. Father's Name (First, Middle, La	<u>·</u> _		1.1.	ojece	Han		r's Name	(First, Middle,			
Maryland	be f lair and of	Be									Mason			
Ĕ	J Mer nark	ဥ	John Russell Sew		_	10h Maili	ng Address				Route Numbe	City or Toy	vn State Ziu	Code)
ā	12 st h and 7 Is r		19a. Informant's Name/Relationship								Huntir	-		
ď.	l and lealt		Mary L. Bolen/Da	ugnter	20b. I	_ 4031 Place of Dispo			Cross		ate	20c. Locatio		
0	if of H		1 ☐ Burial 2 🖔 Cremation 3		m State	cemetery, cre	matory or oth	her place	.	00/1	10001			
Ë	men tant: jury		`4 □Donation 5 □Other (Spe		Lou		-					Balti		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Tratural', or litems 23a or 28a-f show Important: If item 27 is marked other than "natural", or litems 23a or 28a-f show any injury or other traumatic avent, the Medical Examinating must be multipled at once.		21. Signature of Funeral Service Li	ensee Où	My -	$>$ $\frac{3}{1}$	Simple 040 R	Tri ockv	bute ille	Fune Pike	eral and ; Rocky	Cremarille,	ation MD 20	Center 852
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications tha	t caused the dear	th. Do not en	ter the mode	of dying	g, such as	cardiac c	r respiratory ari	est,		Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	•	tastatio	R1add	lar Ca	ncar						Onset and Death
	/Medical		resulting in death)		o (or as a consec		ici da	IICCI						-
	Examiner													
		Jer	Sequentially list conditions, I any, leading to immediate	Due	to (or as a consac	juence of								
	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.										
ó	en ar	Ë	resulting in death) Last	Due	to (or as a consec	quence of):								
8760,	death certificate be executed eattending physicien and d for use as the burial-transit	cai		d										
9	ntifica ng ph as th	Med	IS SERVALE.											
Вох	th ce tendii r use	an/l	IF FEMALE: 23b. Was decedent pregnant		outcome of pregn birth 2 Feta		⊒Ectopic pre	gnancy				1	Date of deliv Month	ery Day Year
	dea ne att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre 9□ Un	gnant at time of o	death 5	Other (spe	ecify)					WIGHT	Day 1 bai
P.0	uires that the de signed by the a Id be detached f	by Physician/Med	9 🗆 Unknown											
	gned be de	by	Part II. Other significant condition	s contributing to	death but not res	sulting in the u	inderlying ca	luse give	in in Part I.	•		_		he cause of death?
D	w requires been sign should be					<del></del>					1 L Y	es 2 □ No	3 ☐ Prol	Dably 4 Unknown
Records,	S ST	Completed									24a. Was a		b. Were auto	ppsy findings available impletion of cause of
Ä	The laste ha	E									perfor 1 ☐ Yes	med? 2X No	death?	2 No
of Vital	ician; Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	(Check only or			
>	Jing Physician:  A. After this certific funeral director,	To B	examiner? 1 ☐ Yes 2 <b>X</b> ] No	Hospital:	☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DO	A Othe	ar: 4 □ Nu	rsing Ho	me 5 Resid	ence 6 x	her (Speci	Hospice
0			27. Manner of Death	28a. Da	te of tnjury onth, Day Year)	28b. Time o	of 28	3c. Injury Work			28d. Describe h			
<u>0</u>	Attending I r death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		o,,,	(2.)	М		Yes 2□	No				
Division	Atte	iffic	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. FIE	ace of tnjury - At h	nome, farm, st	reet, factory,	office			28f. Location (S City or Tow		mber or Rur	al Route Number,
Ö	alor safte al Dir	Certification:	- Cironiales		ilding, oto. (Dpoor	.,,					,	, -,-,-,		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier to Certifying (Check only one)	caminer: On the	the best of my know basis of examinations anner stated.	owledge, deal ation and/or in	th occurred anvestigation.	in my op	e, date an pinion, dea	d place, th occurr	and due to the o ed at the time, o	ause(s) and late and ptac	manner as s e, and due t	tated. o the cause(s)
	oth othio ompl	Me	29b. Signature and title of certifier	.11	,		29c.	License	number		2	9d. Date sig	ned (Month,	Dey, Year)
	₩ <b>\$</b> ₩ Ō		X INA	The	-		1	74	112	10	-	2/1	dou	•
	10		30. Name and address of person w	ha completed or	ause of death (Ite	m 23a) (Tues	Print)	ו כ	12	70		-/ -	707	
	•				001 Mune			Ross	1 · Ro	ckwi	11e. MD	20855		
	Sta	ato	Charles Harrison  31. Date filed (Month Year)		. Registrar's Sign	ature/9	Annak.	Noac	., 10	CLV I.	, 1111	_0000		
	Regist		LER T	7 ZUU4	of the September	A. S.								

DHMH 17 Rev 1/2001

SEWARD

William Sessions 04-01256 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. cm State of Maryland / Department of Health and Mental Hygiene 2004 Unpend Item#23a,27,PerCartificate of Beath 04eg 2. Date of Death 1. Decedent's Name (First, Middle, Last) 15, Physician February William Randolph Sessions 2004 6:04 РМ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City Howard 8004 Main Street, Apartment 202 8. Date of Birth (Month, Day, Year) March 26,1972 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax Days **Funeral** Hours 1 1 2 F Yrs Maryland 218 11 3878 31 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f ahow the Mudical Examiner must be notified at 1 ☐ Yes 2 No MD Ellicott City Howard Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 8004 Main Street Apt 202 21043 United States Itе⊞s 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 23 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1X Never Married 2 ☐ Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify: Specify ģ 3 Widowed 4 Divorced White natural Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Retail 12 should be filed w and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Barton Sessions Jessie Lee Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) oportant: If item 27 ia rv Y Injury or other William Barton Sessions/Father 2550 North Farm Road Ellicott City, MD 21042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Cem. 2-21-2004 Ellicott City, MD 21. Signature of Funeral Service Licensee M01044 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. Collins Den 4112 Old Columbia Pike Ellicott City, MD 21043 W 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Complications of Gastroparesis **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-transil Due to (or as a consequence of) Box 68760 attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 101 Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 \sum No 24a. Was an page 2 certificate has autopsy performed? 2 🗌 No Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene 2 Yes 2 No 2 ER/Outpatient 3 DOA this funerai 28b. Time of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ŏ within 24 hours at To the Funeral D completely tilled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu O.C.M.E. February 18, 2004

State Registrar 31. Date filed (Month, Day, Year)

FFR 1 9 2004

32. Registrar's Signature

s of person who completed cause of death/(hem 23a) (Type, Print)

Spark

111 Penn Street, Baltimore, Maryland 21201

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lity Name (If not institution, given and provided in the little of Disposition of	To see the and number of the second seed of the seed and number of the seed of	Age (In yrs. 22 10c. Ci W	last birthday) Yrs.  ty, Town or Lo  foodlaw  1.S. 13.  16a. Dece (Give life.)  Custo  19b. Mailit 7101  Place of Disponentary, cre- ang Memory Att. Do not ent	If Und Months  If Und	Zip Code  1244  edent of Hisecrity Cuba  2 No  sual Occupa  vork done of  use retired  Servi  Cour  lame of  rother place  1 Pk.  and Address  ark II	ispanic Origin, Mexican Specify:  ation during most in Myra and Numbert, Wo Ceme. ss of Facility gts.	gin? (Speed of working of the role of the	age N Route Number Numb	10g. Citi U.S  16b. Ki  Cos. Maiden  20c. Lo  Balt  k. C.  imore	izen of What  A.  14. Race - A.  Black, W Specify: B ind of Busine  Smetol Sumame)  or Town, State and 212 ceation - City timore  Jones	eath  TIMORE  Birthplace (State or Fore Country)  ryland  10d. Inside City Lity 1 yes 28  Country?  merican Indian, white, etc.  Flack  siss/Industry  Ogy  e, Zip Code)
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nock, or heart failure. List only iate Cause (Final e or condition g in death)	y one cause on eac	ch line.	th. Do not en							z, nar	Approximate Interval Between
Disease or injury lated events g in death) Last	c	r as a consec	INIC quence of):	L	UPU.	3 2	RY	THEM	470	212	
as decedent pregnant the past 12 months?  Yes 2 No Unknown	1 ☐ Live birt 4 ☐ Pregnar 9 ☐ Unknow	th 2 ☐ Feta nt at time of o wn	al déath 3[ death 5[	Other (	(specify)			ag. Bid		Month	Day Year
Other significant conditions of	contributing to dea	ith but not res	sulting in the u	nderlying	g cause give	en in Part I.					Probably 4 Unkn
										24b. Were	autopsy findings avail to completion of cause
								perfe	ormed?	death	to completion of cause i? 'es 2□ No
s case referred to medical						26 Place	of Death			101	65 2010
	Hospital:	patient 2	ER/Outpatier	nt 3 🗆 🛭	DOA Othe	00				6 □Other (S	pecify)
nner of Death	28a. ate of	Injury	28b. Time o						-		
		, Day roar,	irijary	М			No				
determined.	289. Place of			reet, facto	ory, office		2	28f. Location ( City or To	Street and wn, State,	d Number or )	Rural Route Number,
ne)			ation and or in					00 41 110 11110,			
gnatur and title of a rtifier		`		2	esc. License	nedmun e			29d. Date	e signed (Mc	onin, vay, Year)
Mal	meline	in	MD		L	133	910		FERS	> 15	2004
ne and address of person who	completed cause	ot death (Ite	п 23а) (Туре,	Print)							
The state of the s	is case referred to medical miner?  I Yes 2 No ner of Death Natural 5 Pending investigate Accident investigate Suicide 6 Could not determined  entifier 2 Medical Executions  I gnature and title 1 sertifier	As decedent pregnant the past 12 months?   1   Live bir 4   Pregna 9   Unknown  Other significant conditions contributing to deal minner?   Yes 2   No   No   Pregna 9   Unknown  Other significant conditions contributing to deal minner?   Hospital:   In   In   In   In   In   In   In   I	23c. If yes, outcome of pregnant the past 12 months?   1   Live birth 2   Feta   4   Pregnant at time of contributions   1   Live birth 2   Feta   4   Pregnant at time of contributions   1   Live birth 2   Feta   4   Pregnant at time of contributions   1   Live birth 2   Feta   1   Live birth 2   Live birth 2   Live birth 2   Feta   1   Live birth 2   Live b	Ass decedent pregnant the past 12 months?   1   Live birth 2   Feat I death 3   1   Live birth 2   Feat I death 5   1   Live birth 2   L	23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 3   Ectopic   1   Live birth 2   Fetal death 5   Other (9   Unknown)   1   Live birth 2   Fetal death 5   Other (9   Unknown)   1   Live birth 2   Fetal death 5   Other (9   Unknown)   1   Live birth 2   Fetal death 5   Other (9   Unknown)   1   Live birth 2   Fetal death 5   Other (9   Unknown)   1   Live birth 2   Fetal death 5   Other (9   Unknown)   1   Live birth 2   Fetal death 5   Other (9   Unknown)   1   Live birth 2   Fetal death 5   Other (9   Unknown)   1   Live birth 2   Fetal death 5   Other (9   Unknown)   2   Fetal death 5   Other (9   Unknown)   2   Live birth 2   Fetal death 5   Other (9   Unknown)   2   Live birth 2   Fetal death 5   Other (9   Unknown)   2   Live birth 2   Fetal death 5   Other (9   Unknown)   2   Live birth 2   Fetal death 5   Other (9   Unknown)   2   Live birth 2   Fetal death 5   Other (9   Unknown)   2   Live birth 2   Fetal death 5   Cother (9   Unknown)   2   Live birth 2   Fetal death 5   Other (9   Unknown)   2   Live birth 2   Fetal death 5   Other (9   Unknown)   2   Live birth 2   Fetal death 5   Other (9   Unknown)   2   Live birth 2   Fetal death 5   Other (9   Unknown)   2   Live birth 2   Live bir	Ass decedent pregnant the past 12 months?   1	23c. If yes, outcome of pregnancy the past 12 months?   1   Live birth 2   Festal death 4   Pregnant at time of death 5   Other (specify)	23c. If yes, outcome of pregnant the past 12 months?   1	23c. If yes, outcome of pregnancy the past 12 months?   1	23c. If yes, outcome of pregnant the past 12 months?    Yes 2   No	23d. Date of Month   2   Feld death   3   Ectopic pregnancy   23d. Date of Month   2   Feld death   4   Pregnant at time of death   5   Other (specify)   23e. Did tobacco use contributed   1   Yes   2   No   3

DHMH 17 Rev 1/2001

Physician Medical Examiner    DONALD P. SULLIVAN   FEBR   Funeral Director   4611 BELVIEW AVENUE   S. Social Security Number   6. Sex   10X M 2   F   7. Age (in yrs. last birinday)   If Under 1 Year   If Under 2 Hrs. 8. Date Months   Days   Hours   Min. MAR   Mark   M	Reg. No. 2004 0520
S. Social Security Number   S. Sex   T. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   S. Date (In Yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   S. Date (In Yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   S. Date (In Yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   S. Date (In Yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   S. Date (In Yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   S. Date (In Yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   S. Date (In Yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   S. Date (In Yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   S. Date (In Yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   S. Date (In Yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   S. Date (In Yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.	of Death the Day Yeer UARY 16, 2004  4c. County of Death NA
The property of the property o	o of Birth htth, Day, Year)  CH 17, 1953  NA  9. Birthplece (Stete or Foreign Country)  MD
Elementary/Secondary (0-12)  12  College (1-4or 5+)  12  CORRECTIONAL OFFICE  18. Mother's Name (First, Middle, Last)  WILEY LARK  EDNA SU  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route  3706 GARRISON BLVD B  20a. Method of Disposition  1 ABurial 2 Cremation 3 Removal from State  1 A Donaton 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility WYLIE  638 N. GILMOR STREET  Physician  [Medical Examiner]  Sequentially list conditions, if any, leading to immediate any, leading to immediate any, leading to immediate and lines.  Due to or as a consequence of):	10d. Inside City Limits 1 🎇 Yes 2 🗆 No
20a. Method of Disposition (Specify)  20b. Place of Disposition (Name of cemelery, crematory or other place)  1 X Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respire shock, or heart failure. List only one cause on each line.  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respire shock, or heart failure. List only one cause on each line.  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Sequentially list conditions, if any, leading to immediate cause. Sequentially list conditions, if any, leading to immediate cause. Sequentially list conditions. Due to or as a insequence of):	Black, White, etc.  Specify: AFRICAN  AMERICAN  16b. Kind of Business/Industry  STATE OF  R  MARYLAND  Middle, Maiden Sumame)  LLIVAN LARK
Physician /Medical Examiner  23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respire shock, or heart failure. List only one cause on each line.  Immedical disease or condition resulting in death)  Due to (or as a consequence of):  Due to or as a sequence of):  Due to or as a sequence of):	ALTIMORE MD 21215 20c. Location - City or Town, State OWINGS MILLS MD FUNERAL HOME PA
pen per cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d. Due to (or as a consequence of):	Onset and Death
So we will be set to be se	23d. Date of delivery  Month Day Year
	e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown
The law required of the la	1. Was an autopsy performed? Per 2 1 Yes 2 No
27 Manner of Death 28a Date of Injury 28b Time of 28c Injury at 28d Dec	Residence 6 Other (Specify) scribe how injury occurred ation (Street and Number or Rural Route Number, or Town, State)
1   1   2   2   2   2   2   2   2   2	to the cause(s) and manner as stated, etime, date and place, and due to the cause(s)
29b. Signature and title of certifier  29c. License number  272	29d. Date signed (Month. Dey, Year)
30. Name and address of person who completed cause of death (Item 2300 Jarrisin 2300 Jarrisin 31. Date filed (Month, Day, Year)  32. Registrate Signature	Blad 21216

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05201 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month E February **Physician** Earl 2004 9:55 P M W. Snyder /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Rossville Rosedale Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, FEB 8, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F 1914 Pennsylvania 90 184-03-9772 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic svent, it is Medical Examinat must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Baltimore Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 4526 Fitch Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tech Writer U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Chester Snyder Cora Berger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4526 Fitch Avenue Judith E. Roberts/Daughter Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 2-18-04 Baltimore, MD 21. Signature of Funeral Service Ligansee
Thomas Gregory <sup>22</sup> Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimor Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical HOWER **Examiner** HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner nding physicien and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown DEMENIJA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D55306 February 18, 2004 RESSUITE PROFF CIE BAGO HD 2/237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1232 FACERD DENNIS H'ODIE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 9 2004 Jacks Registrar

State of Maryland / Department of Health and Mental Hygiene 2 05202 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day ELLEN MADELINE /Medical SMITH 17 2004 FEBRUARY 4a. Fecility Name (If not institution, give street and number,

TOTHES HOPKINS BAYVIEW MEDICAL CENTER BALTIMUTZE

TOTHES HOPKINS BAYVIEW MEDICAL CENTER BALTIMUTZE

6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Months Days Hours Min. (Month, Day, Year) 4a. Fecility Name (If not institution, give street and number) Examiner 4c. County of Death **Funeral**  Birthplace (State or Foreign Country) 71 212-30-3623 **Director** 1-11-1933 Maryland Usual Residence of Decedent 10a. State 10b. County or 28e-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at MD n/a Baltimore 1X Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3806 Claremoont Street 239 21224 USA Pages 1 and 2 should be filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Š Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed th and Mental Hygiene.
77 is marked other then "natur traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Homemaker In own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William F. Dannenfelser Ruth Ellen Cooper 19a. Informant's Name/Relationship (Type, Print) friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health iftem 27 i Regina Gray 3806 Claremont St., Baltimore, Md. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State to Burial 2 ☐ Cremation 3 ☐ Removal from State 2/20/04 ` 4 Donation 5 ☐ Other (Specify) Dulaney Valley Baltimore, MD 22. Name and Address of Facility Joseph N. Zannino Jr. 21. Signature of Juneral Service Licensee drea Saurero 263 S. Conkling St. Baltimore, MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HYPOXEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PULMONARY Sequentially list conditions, r any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) death certificate be executed the burial transit CONGESTIVE HEART FALURE that initiated events resulting in death) Last Due to (or as a consequence of): 68760 attending physician for use as the buria Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death Day Year 5 Other (specify) Ö 9 Unknown 9 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Completed 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manney of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division Attanding 1 Natural 5 Pending death. Hospital or Attand 24 hours after death Funaral Diractor: A 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TWO RESIDENT 23009 FEBRUARY 17, 2004 D 30. Name and address of person who obmpleted cause of death (Item 23a) (Type, Print) TANESHA HANDY 4940 EASTERN AVENUE BALTIMORE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 1 9 2004

			For State	State of Maryla	and / Depa	artment of	f Health and	d Mental Hyg	iene	2004	05203
		80	Ragistrar  1. Decedent's Name (First, Middle, Las		<i>Cel</i>	incate C	, Deall	2. Date of Dea	th		3. Time of Death
*	Physicia	an	Virginia		hompson			Honth Tebricas	Day 16	h 200h	Q=HOAM
	/Medic Examin	_	4a. Facility Name (If not institution, give		TOMPSOTT	4b. City, Town	n, or Location of De		11	ounty of Deeth	
	LAGIIIII	-	Union Mem. Hosp	oital		Balt:	imore		1	NA	
	Funeral		Social Security Number     6. Se		s. last birthday)	If Under 1 Ye Months Da		lin. 8. Date of Birth	Year)	9. Birthp Cour	lace (State or Foreign
4	Director		217-22-1007	□M 2½ F 71	Yrs.			7-18-3		Md.	
	pur *		Usual Residence of Decedent  10a, State 10b, County	10c. (	City, Town or Lo	cation				1	0d. Inside City Limits
	Aarylia Faho	ō	Md. NA		Ba	ltimore					1. Yes 2 No
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	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f ahow than "Medical Examinar must be rediffed at	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No-	14.	Race - Americ Black, White,	
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ary	2 should be 1 and Mental 1 is marked of raumatic eve		19a. Informant's Name/Relationship (7					Rural Route Numbe			
Σ	is 1 and 2 of Health a itam 27 is other trau		Nia Morgan Gr	anddaughter				Ave., B			
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		matory or other	place)	Date		tion - City or To	
Ě	Pag ment ant:		* 4 ☐ Donation 5 ☐ Other (Specify	)	Baltimo			-23-04		timore	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f ahow any injury or other traumatic event, the Medical Examinat must be notified at ance.		21. Signature of Funeral Service Licen	see			.H. East	B. 1101 E.		ore, Mo	1. 21202
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,	Dhypinian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.							Onset and Death
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876	physic physic the t	dicai		. d							
Box 6	ding p	Physician/Med	IF FEMALE:	23c. If yes, outcome of pred	gnancy				23	d. Date of delive	erv
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	law requires that the de as been signed by the a 2 should be detached t	by Pt	Part II. Other significant conditions of	ontributing to death but not r	resulting in the u	inderlying cause	given in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
Records,	w requires been sign should be							1 🗆 Y	'es 2. 🖫	No 3□Prot	pably 4 🗆 Unknown
000	aw re	ompieted						24a. Was	an :	24b. Were auto	ppsy findings available mpletion of cause of
æ	9 - 6	E						perfo	med? 2 No	death? 1 ☐ Yes	
Vital		BeC	25. Was case referred to medical examiner?				26. Place of	Death (Check only o	ne)		
of V	di is	10	1 ☐ Yes 2 ☑ No	Hospital: 1 1 Inpatient 2	ER/Outpatie		Other: 4 Nursin	ng Home 5 ☐ Resid			<b>(y</b> )
n o		.E	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?	28d. Describe h	low injury	occurred	
sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not b		t hama farm at		1 ☐ Yes 2 ☐ No	28f Location (9	Street and	Number or Rus	al Route Number,
Division	Dir Dir	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)	reet, factory, of	iice	City or Tow			
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in		(Check only 2 Medical Exar	nysician: To the best of my l niner: On the basis of exam	knowledge, dear nination and/or in	th occurred at the	ne time, date and p my opinion, death o	lace, and due to the occurred at the time,	cause(s) ar	nd manner as s lace, and due t	stated. the cause(s)
	thin 2, the both supplet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Lid	cense number		29d. Date	signed (Month,	Day, Year)
-	To To		1	Rugherran							
	8		30. Name and address of person who	1	Item 23a) (Tyne	Print)	DOI EAC	TUNIVER	SITY	PK WA	1 2007
	Ü		GOURT VEER	ARACIHANA	v/			ORE, MD			
7	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	head s			, _		
	Danie.		rrp 1 Q 2	nn A A Contains	EP AND	The same of the sa					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 14 05204 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Taylor Month Year **Physician** Jacqueline 1:42 AM Februar 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Harbor Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M 200 F **Director** Usual Residence 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in then "naturel", or fems 23s or 28e-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director timore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 Funeral Was Decedent Evel Armed Forces? Race - American Indian, Black, White, etc. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Tes 2 No 1 Yes 2 1 lac þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othe any injury or other traumatic event gone. 17. Father's Name (First, Middle, Last) Minnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 104 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeret Service 11CRS - Vaugher G. Greene toward Setvices 5151 Balto. National Pike 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Chronic respiratory disease or condition resulting in death) a Aculo /Medical Due to (or as a consequence of): Examiner Endocarditis months Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner  $(\pm)$ the attending physician and hed for use as the burial-transit unknown that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 12 No 3 Probably 4 □Unknown abuse Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical

certificate has Hospital or Attending Physician: After this Division death. To the Hospital or Attence within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HHC3001 B Hanover Street, Battimore 32 Registrar's Signature

Florence

29d. Date signed (Month, Day, Year)

February

11th, 2004

31. Date filed (Month, Day, Year) FEB 1 9 2004 Registrar

DHMH 17 Rev 1/2001

Aslinia, MD

29c. License number

21225

16

	•	1 - For Amend Item#5, per	State of Maryland Dr,G829,3/12/200	1 / Department of Healt 4 , gap Certificate of Dea			2004	05205
Physici	an	Decedent's Name (First, Middle, Last)	Enith	TAYLOR	Mo	te of Death onth Da		3. Time of Death 2134 M
/Media	cal	MELINDA  4a. Facility Name (If not institution, give s	street and number)	. 4b. City, Town, or Locati		bruary to	: County of Death	1
Funeral Director	lei	The Johns Hop 5. Social Security Number 6. Sex 214-69-4065	Kins Hospi 7. Age (In yrs. 12	Had Baltimore ast birthday) If Under 1 Year If Un Months Days Hou	ider 24 Hrs. 8. Da	te of Birth onth, Day, Year)	Co	hplace (State or Foreign untry)  ARM AND
<b>D</b> .		Usual Residence of Decedent  10a, State 10b, County	10c City	, Town or Location				10d. Inside City Limits
Maryla f shov	or	Maryland St. M	neu's	_	BERS			1 ☐ Yes 2 🗹 No
r 28a-	irect	10e. Street and Number	,,,,,	10f. Zip Code		10g. Cit	tizen of What Co	1.0
ath wit	raiD	17785 RIVE		Drive 2069			14. Race - Amer	
us after de	by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.\$ Armed Forces? <ul> <li>1 ☐ Yes 2 ☑ No</li> <li>If Yes, Give Year or Dates:</li> </ul>	S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex  1 ☐ Yes 2 ☑ No Specify	dican, Puerto Rican,	etc.)	Black, White	
Deficiency in the property of the particle of the many and permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23e or 28e-1 show important; or items 23e or 28e-1 show any injury or other traumatic event, the Medical Example confiled at ance.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during r life. DO NOT use retired)	most of working	16b. K	(ind of Business/I	Industry
filed w Hygier ther th		17. Father's Name (First, Middle, Last)		18. M	other's Name (First,	Middle, Maiden	Sumame)	
y call	To Be	LAWRENCE	_	Taylor I	DIANC	Lou	ise 1	Brinkley
2 shou and N le mar		19a. Informant's Name/Relationship (Ty	E- U	19b. Mailing Address (Street and Nu		7	-	
t and the alth ther tr		LAWRENCE TAY/O, 20a. Method of Disposition		ace of Disposition (Name of	en 5ho.		Ocation - City or 1	TIMBERS MD
Pages Tent of Pint: If Ite		1 ☐ Burial 2 🗓 Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crematory or other place) CEN mount Cencter,	FEB 18.7		. /	
Dallulli permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License		22. Name and Address of Fa	acility	JR. 1	-vnera	a Horse
		0//20	un	22. Name and Address of Fa	Ikling 5	treet i	BA/to 1	
	П	23a. Part1. Enter the disease, or compliant shock, or heart faill e. List only or				ratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical	П	Immediate Cause (Fin- disease or condition resulting in death)		Me Prematu	rity			3 hours
Examiner			Due to (or as a consequ	ence or):				
P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Unidenying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):				
of COU, cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):				
of ou,	dicai E			,				
do rifficate	6)	IE SELVALE						
ath cert	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 Live birth 2 ☐ Fetal	death 3 Ectopic pregnancy			23d. Date of deli-	very Day Year
the de	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at time of de 9□Unknown	ath 5 Other (specify)				
The law requires that the death certifur the has been signed by the attending rage 2 should be detached for use as	by Ph	Part II. Other significant conditions cor	tributing to death but not resu	Iting in the underlying cause given in Pa	art I. 23	e. Did tobacco	use contribute to	the cause of death?
law requires that see that see the second see the second s						1 Yes 2	<b>X</b> No 3□ Pro	obabiy 4 Unknown
a law nas be	Completed				24	a. Was an autopsy	24b. Were aut prior to c death?	topsy findings available completion of cause of
The The licate Ir. The r. pag					1	performed Yes 2 No		2 🗆 📉 No
VILCII VSICIAN: S certifical director, p	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 VInpatient 2 □ E	Other	lace of Death (Chec Nursing Home 5	5. 10.00	6 □Other (Spec	eify)
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tlon: T	27. Manner of Death  1 Natural 5 ☐ Pending  1 Accident investigation		28b. Time of lnjury at Work?  M 1 □ Yes 2	28d. De	escribe how inju		
or Attending after death.  Diractor: After in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined		me, farm, street, factory, office	28f. Lo	cation (Street ar	nd Number or Ru	ral Route Number,
rs afte	Cert	4   Notificide	building, etc. (Specify,	/		y or rown, State	,	
Hosp 24 hou Funei Hely fil	edical			viedge, death occurred at the time, date ion and/or investigation, in my opinion,				
Fo the within 7 Fo the comple	Med	29b. Signature and title of certific r	TO A	29c. License numb		29d. Da	te signed (Month	n, Day, Year)
- >- 0		· Carry	1 10074		5-000	C	12/16	104
		30. Name and address of person who co	mpteted cause of death (Item	23a) (Type, Print) Carolyn	1 Boyla	n, MD	> 11	2000
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat		Molte	J. 100	740 MI	) CICY /
Regist	17	FFD 1 0 2004	Brace &	Sparks				

State of Maryland / Department of Health and Mental Hygiene 2004 05206 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** DUZER 2:05 VAL 2004 10 DEBRUARU /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Oeath 4c. County of Oeath Examiner HOSPITAL 24 Hrs of Birth Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Oays Min. Hours 1 XM 2 □ F Months April 11,1922 Director 288-12-6638 New York 81 Usuel Residence of Oecedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Potomac Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code "natural", or Items 23a 20854 United States 11300 Hawhill End death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No ff Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or flen any injury or other traumatic event. The Medical Experiment 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lockheed Martin Accountant (unk) (unk) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine M. Van Duzer/Spouse 11300 Hawhill End; Potomac, MD 20854 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Crematory 02/17/2004 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.
Simple Tribute Funeral and Cremation Center nemin 1040 Rockville Pike; Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** AWTE HAILURE RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed BRAIN that initiated events resulting in death) Last and Oue to (or as a consequence of): attending physician P.O. Box 68760. Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de use 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown n signed by ti 1 be dr 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Minpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Oeath 28b. Time of 28c. Injury at Work? 28d. Oescribe how injury occurred After 1X Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide within 24 hours after To the Funeral Dire the Hospital filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Oate signed (Month, Day, Year) ES - 000 M.D 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET BALTIMOLE, MO AMAR KRISHNASWANY 600 WOLFE NORTH 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State Registrar 9

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Bonaventure E. von Paris February 16 2004 1:00A M /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 711 Maiden Choice Lane Catonsville

If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

April 25,1912 Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 215-03-6780 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ust be notified at Maryland Baltimore Catonsville 1 ☐ Yes 2 ☑ No Director 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ 23a 711 Maiden Choice Lane 21228 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status other traumatic event, the Medical Examiner filed within 72 hours after 1⊠Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 H No Specify: þ If Yes, Give Year or Dates: Specify: White WW II 3<sup>™</sup> Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Executive Moving Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pepartment of Health and Mental Procrtant: If item 27 is marked oily injury or other transmissions. ould be f Mental I Bonaventure von Paris Theresa Anton 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur G. Feeney (Personal Rep) 2703 Summers Ridge Drive Odenton, Maryland 21113 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State The Sacred Heart of Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Jesus Cemetery 2-20-2004 Baltimore, Maryland permit. 21. Signature of Puneral Service License 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
2 years Immediate Cause (Final disease or condition resulting in death) Conjustive heart for here **Physician** /Medical Due to or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical use as i the attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 Other (specify) P.O. 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records. cate has been sig 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \[ \text{Yes} \quad 2 \[ \text{No} \] 24a. Was an certificate has performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funera After t 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number DS3445 FEB 17. dress of person who completed cause of death (Item 23a) (Type, Print) oster de sunte 311 Touson M 21200 THANKER m 31. Date filed (Month, la Spar) 1 9 2004<sup>82</sup> Regilirar's Signature State Registrar

John Watson 04-00566 RJ 1-

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2004 05208

For	State of Maryland / Department of Health and Mental Hy	/giene
State Registrar	Certificate of Death	Reg. No.

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Lygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. Ite Medical Examiner nust be retified at ODGs.

Baltimore, Maryland 21215-0036 Physician /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

T = 1										_	ay	Year	
John	Watson								Janua	iry_2	20,	2004	0320 P
	If not institution, give				46	c. City, Town, o	or Location	of Death		4	c. Count	ty of Death	h
227 S	South Broa	dway St	reet			Baltir	nore						
5. Social Security N	Number unk 6. Se		7. Age (In yrs	. last birtl		Under 1 Year onths Days		24 Hrs. Min.	8. Date of B	irth	.)	9. Birth	nplace (State or Foruntry)
	1.	X) M 2□F	51	Y	rs.	Ontris Days	Hours	IVIII).	May 7,	195	2	Col	unuy) unik
Isual Residence of	f Decedent												
0a. State	10b. County				or Location	on							10d. Inside City Lin
MD			В	alti	more								1X Yes 2 □
10e. Street and Nur	mber				1	10f. Zip Code				10g. C	itizen of	What Cou	untry?
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(Spec	15. Decedent's Ed cify only highest grad	de completed)		104.1	(Give kind	's Usual Occup d of work done NOT use retire	during mos	t of work	<sub>ding</sub> unk	16b. F	Kind of E	Business/II	ndustry 1
Elementary/Seco unk		College (1-	4or 5+)		me. DOT	VOT USE TELLE	<i>a)</i>						
		ınk											
7. Father's Name	(First, Middle, Last)					unk	18. Moth	er's Nam	e (First, Middle	e, Maidei	n Sumai	me)	u
19a. Informant's Na	ame/Relationship (7	ype, Print)		19b.	Mailing A	ddress (Street	and Number	er or Rur	al Route Numi	ber, City	or Town	, State, Zi	ip Code)
O.C.M.E											2000	er.	
0a. Method of Disp			20b.	Place of I	Disposition	on (Name of		arti	more, 1	20c L	2120 ocation	City or T	own, State
	☐ Cremation 3 ☐ 5 🔀 Other (Specify		iate	cemetery	r, cremato	ry`or other pla	ce)					,	, -1
	ona Dd S.	Wade,	irecto	r	22. Na	me and Addre	ess of Facilit	oard	655 W	. Ba	ltim	ore S	Street
	1-0/1//////	11 811	10//	-									
23a. Pett1. Enter the shock, or heal immediate Cause (disease or condition	on	ne cause on ea	ich line.	ith. Do no	Balt ot enter th	imore, ne mode of dyn	MD ng, such as	2120 cardiac	1	arrest,			Approximate Interval Between Onset and Death
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State Registrar

31. Date filed (Month, Day, Year)

FEB 1 9 2004

ZABILICA 17

AU 111 Penn Street, Baltimore, Maryland 21201 32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 05209 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Emily Weiford 5<u>,</u> January 2004 2:00 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 247 Carvel Road Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov 24, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F 82 053-16-7998 1921 Director Germany Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Items 23s or 28e-f ahow 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumatic avant, the Medical Examiner must be notified at MD Anne Arundel Pasadena 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 247 Carvel Road 21122 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: white 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) make up artist Max Factor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carl Fredericks Emma Vogelsong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda McMillion/daughter 247 Carvel Road pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages i Department of H Importent: If Ite any injury or ot once. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director 23a. Pan1. Enter the disease, or complications that caused the death. shook, or heart failure. List only one cause on each lige. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physicien Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖃 No Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 2 Z No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 this certificate has autopsy performed? 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. • Funeref Director: A the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 18 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) within 2. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 03/322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4304 MOUNTAIN ROAD, PASADENA, M21122 GARG M) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

FFB 1 9 2004

		For State Registrar	State of Maryland	Certif	icate of l	Death		Reg. No.	
Physicia /Medic		Decedent's Name (First, Middle, Last     George		Wright			2. Date of De Month Februa	Day Y	3. Time of Death 204 4:55 P
Examine		4a. Facility Name (If not institution, give Sineri Hospital			-	Location of Death	1	4c. County of NA	Death
Funeral Director		5. Social Security Number 6. Se		st birthday) If	Under 1 Year lonths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 9–16	iy, Year)	D. Birthplace (State or Forei Country) Va.
Maryland -f show		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Locati	on				10d. Inside City Limit
ne Mary 8e-f sh	ctor	Md. NA		Baltimo					YOYes 2 N
death with the ms 23a or 28e rount be not	0	10e. Street and Number 2128 Cliftwood A	1110		10f. Zip Code 2121	2		10g. Citizen of Wh	at Country?
Ind 21215-0036  be filed within 72 hours after death with the Maryla ital hygiene. Ital hygiene. In other than "natural", or items 23a or 28e-f show event, the Medical Examiner round be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1☑Yes 2☐No IfYes, Give Year or Dates:			ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No o Rican, etc.)	14. Race - Black,	American Indian, White, etc. Black
21215-0036 d within 72 hours aft giene. or than "natural", or ure Medical External.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)	(Give kind life, DO	NOT use retired	during most of wor	king	16b. Kind of Busi	ness/Industry
d 21 filed wi Hygien ther th		10th grade 17. Father's Name (First, Middle, Last)		Labo	rer	18. Mother's Nam	ne (First, Middle	Varie	S
Iryiand ZIZ should be filed withir nd Mental Hygiene. marked other than imatic event, IIE M	To Be	Jesse	Wright	2		Eva		Mae	Johnson
Maryland d 2 should be file tith and Mental Hy 27 Is marked oth treumatic event		19a. Informant's Name/Relationship (7)						er, City or Town, St	
the ar		Rose Callaway S  20a. Method of Disposition  1   Burial 2   Cremation 3	CC	ace of Disposition metery, cremator	on (Name of	od Ave.,	Date	re, Ma. 20c. Location - Ci	21213 ty or Town, State
Baltimore, permit. Pages 1 ar Department of Hes Importent: If item any injury or othe		*4 □Donation 5 □ Other (Specify, 21. Signature of Funeral Service License	1////	1	ame and Addres	ss of Facility	0-04 Baltin	Arbutus more, Md.	21202
n sassa		23a. Pag 1. Enter the disease, or comp		1	ch F.H.		1101	E. North	Ave.
6876( cate be physicia the bur	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence)  Due to (or as a consequence)  d.  23c. If yes, outcome of pregnar	ence of):				23d. Date	of dalivary
VISION OF VITAL HECONTS, P.O. BOX 6 Attending Physicien: The law requires that the death certificate has been signed by the attending ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3□Ect	topic pregnancy her <i>(specify)</i>			Month	
Cords, r	þ	Part II. Other significant conditions co	7	iting in the under	rlying cause givi	en in Part I.			ute to the cause of death?  Probably 4 □Unkno
The law requate has been page 2 should	Completed	diabetes me congestive he		~	<del></del>	· · · · · · · · · · · · · · · · · · ·	24a. Was auto perfo	an 24b. We pricomed? dea	re autopsy findings available to completion of cause ath?  Yes 2 No
Vital Ficien: The certificate rector, pag	Be	examiner?	4		O#5	26. Place of Dea	th (Check only o	one)	
Division of Vital Records, for Attending Physicien: The law requires that death.  Director: After this certificate has been signe in by the funeral director, page 2 should be death.	tion; To	1 Yes 2 No  27. Manner of leath 1 Natural 5 Pending 2 Accident investigation	1   Inpatient 2   1   Inpatient 2   1   2   1   2   2   2   2   2   2	28b. Time of Injury	28c. Injun Worl	on 4 ☐ Nursing H y at k? Yes 2 ☐ No		dence 6 Other	
- Fa:= -	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street,	factory, office		28f. Location ( City or To	Street and Number wn, State)	or Rural Route Number,
	~	Committee of the Commit	rsician. To the best of my know	vledge, death us ion and/or invest	curred at the tin tigation, in my o	ns, date and place, pinion, death occur	, and due to the rred at the time,	causs(s) and mann date and place, and	or as stated.
pite urs aret	edical Ce	29a. Certifier (Check only one)  1X Certifying Pity 2 Medical Exam	and manner stated.						1 009 (0 (119 02039(5)
To the Hospitel within 24 hours a To the Funerel completely filled	Medical Co	29a. Certifier (Check only only) 2 Medical Exam 29b. Signature and title of certifier	and manner stated.		29c. Licenson			29d. Date signed (	

State of Maryland / Department of Health and Mental Hygiene 2004 05211 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Helen Wierciszewski 4:10 A **February** 17 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care Dulaney Towson 5. Social Security Number 7. Age (In yrs. last birthday) Under 1 Year onths Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Hours Min. 216-09-9810 Director 85 July 23 1918 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Exeminer must be notified at 1 ☐ Yes 2 反 No Director Baltimore Rosedale Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1822 Hanford Road 21237 United States or Itema 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Marned Maryland 21215-0036 1 ☐ Yes 2X No Specify If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Itam 27 is marked other ther 6 Machine Operator Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be fi Be Dondalski Stanislaus Josephine Sumowska 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 28056 Adkins Road, Salisbury, Maryland 21801 Dolly Hall - Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tment of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6 Department of Important: If any injury or once. 4 Donation 5 Nother (Specify) Entombment Gardens of Faith 02/20/04 Baltimore, Maryland permit. 22. Name and Address of Facility
David J. Weber Funeral Homes, P.A.
401 S. Chester Street, Baltimore, Maryland 21231 21. Signature of Funeral Service License Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner THEMONMY S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed IV Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.O. 1 detached the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 No 3 Probably 4 □Unknown 1 ☐ Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 🔲 No 1 Yes 2 No 1 Tyes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2 ☐ No Certification: To 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) I in by filled the Hospitel Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D 55306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENNIS 12 oad 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 19

2004

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	/Medic Examin		4e Fecility Neme (If not institution, give street and number)	4b City, Town, or	Location of Deeth 4c. County of Deeth	
		•	5. Social Security Number 6. Sex Zage (In yrs. lest b	irthday) If Under 1 Year If Under 24 Hrs		7
	Funeral Director	0	13-26-7782 1 M 21XF 85  Usuel Residence of Decedent	Yrs. Months Days Hours Min.	11418 Maryland	ر.
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	r 28a-f	Director	10e. Street end Number	timore  10f. Zip Code	10g. Citizen of Whet Country?	
	urs after death with the Manylan al', or items 23a or 28a-f ehow Examiner must be notified at		1503 Metrose Avenue	21212	Specify Yes or No. 14. Race - American Indian,	
	ftar dea	Funeral	11. Merital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ▼ No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)  14. Race - Arientzari molari, Black, White, etc.	
0050	iral', o	þ	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Specify: Black	
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lary	d 2 should b th end Menta 7 is merked treumstic e			b. Mailing Addrass (Street and Number or Re	ural Roud Number, City or Town, Stete, Zip Code)	
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Baltimore	of the second		1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Comete	ery, crematory or other place) SANT REST (EMETER)	12/17/04 TOWSON MD	
3alti	permit. Pag Departmant Important: I any injury once.		21. Signature of Funeral Service Licensee	22: Name and Address of Facility	ene Funeral Services	
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-	Physician		shock, or heart failure. List only one cause on each line.	o not enter the mode of dyung, such as cardia	Interval Between Onset and Death	
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  e.   at (un)	to thrive		
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	7	)	30. Name and eddress of person who completed cause of deeth (Item 23e)	(Type, Print)	Ballimore, MD 21201	
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DHMH 17 Rev 1/2001

ORIGINAL

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			State of Marylar	•	cate of L			leg. No. 20		05214 3. Time of Death	
	Physician	ANNA KATHARYN WORTHINGTON  Month Dey Yea FEBRUARY 17. 2004									
	/Medical Examiner	4a Fecility Neme (If not institution, give	4c. County		1:55 P.M.						
		ST. JOSEPH MEDICAL							TIMORE		
	Funeral Director	5. Social Security Number 6. Set 1 207-03-9063	7. Age (In yrs. M 2 XF 84		nths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 3/19/1	, Year) 9 <b>1</b> 9	9. Birthplac Country PENNS	ce (State or Foreign y) SYLVANIA	
	yland m	10a. State 10b. County		ty, Town or Location	1				100	d. Inside City Limits	
	Ba-fall	MD BALTIMO	ORE TO	OWSON						1 □ Yes 2√ No	
	affer deeth with the Main frem 23e or 28e-fa	10e. Street end Number 1152 E. GYPSY LAN	IE	10	5		USA				
020	is 1 and 2 should be filled within 72 hours after deeth with the Maryland of Health and Mental Hygiene.  Item 27 is marked other than "natural", or itema 236 or 28s-f show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Maritel Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW∏∏	J,S. 13. Was D If Yes,	Decedent of Hi , specify Cuba les 2 X No	spanic Origin? (Spen, Mexican, Puerto Specify:	ocify Yes or No- Rican, etc.)	Blac	e - American ck, White, etc	C.	
21215-0020	ed within 72 hours s ygiene. For than "natural", o rt, the Medical Exer- Completed by	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5+)		of work done o OT use retired,	tion uring most of worki	ing	16b. Kind of Bu		stry	
<b>d</b> 2	Hygie of the Co	12TH GRADE  17. Fether's Name (First, Middle, Last)		HOMEMAI	KER	18. Mother's Name	(First, Middle,	Maiden Sumam	10)		
/ian	Mental H Mental H arked ott attc ever	ROBERT WAGNER				ESTELL	E CAMPB	ELL			
Maryiand	and Me	19a. Informant's Name/Reletionship (Ty				and Number or Rure				ode)	
	1 and lealth m 27 ther tr	ROBERT WORTHINGTON  20a. Method of Disposition		2117 W		ROAD T	IMONIUM Date	, MD 2 20c. Location -	1093 City or Towr	n. State	
nor	eges ant of it t: If its y or o	1 ☐ Burial 2 ☑ Cremation 3 ☐ F	temoval from State	cemetery, crematory TRO CREMA:	y or other place	1	19/04		-		
Baitimore,	parmit. Peges 1 and 2 Depertment of Health s Important: If Item 27 is any Injury or other tra once.	21. Signature of Funeral Service Licens			-	s of Facility THE					
Ď	Depe Impo	Hattu V.	Shura			RAVEN BLV		SON, MD			
	Physician	23a. Pert1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the dea ne cause on each line.	th. Do not enter the	mode of dying	g, such as cardiac c	or respiratory arr	rest,	i Ir	Approximate Interval Between Onset and Death	
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Æ.	hysician: Tha law his certificate has buildiractor, pege 2 s						10Y	us 3KNo	10	Yes 2⊠No	
Vita	entification:	25. Was case referred to medical examiner?	lospital:		Othe	26. Place of Death	TE T 87-33			112	
Division of Vital Records,	ding Physic h. Atter this of funaral dira tion: To	1 Yes 2 No  27. Menner of Death Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Dey Year)	SER/Outpatient 3E 28b. Time of Injury	28c. Injun Won	4 Littlising flo	me 5□ Resid 28d. Describe h				
Divisi	To the Hospital or Attending Phys within 24 hours after deeth. To the Funeral Director: After this complately filled in by the funeral di Complately filled Certification: To Medical Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		actory, office		28f. Location (S City or Tow		er or Rural F	Route Number,	
1	Hospita     24 hours     Funeral     ilataly fille     clical C	29a. Certifier (Check only one) 12 Certifying Physical Exami	sician: To the best of my knoner: On the besis of examination and manner stated.	owledge, deeth occu ation and/or investig	urred at the tim lation, in my op	e, date and place, a ninion, death occurr	and due to the c ed et the time, c	ause(s) and ma late and place,	nner as stet and due to ti	ted. he cause(s)	
		29b. Signature and title of dertifier			29c. License D 21	•575	2	29d. Date signer	8 - 04		
	10+1	30. Name end address of person who co		m 23a) (Type, Print) YORK RD.	STE 200	COCKEY	SVILLE, N	AD 210	30		
ı	State Registrar	31. Dete filed (Month, Day, Year) FFR 1 9 2	32. Registrar's Sign	ature A	No.						

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2004 State AMEND ITEM #19a PER FH G8:28 2/19/04 Oprtificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEBRUARY 15, 2004 WEISS 11:58 P M AARON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 3 PELLINORE COURT #3 PIKESVILLE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month Day Year) DEC. 9,1922 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours 81 Yrs. 199-12-3934 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Exeminer must be notified at 1 ¥Yes 2 □ No Directo MD WORCESTER OCEAN CITY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21842 11604 COASTAL HIGHWAY #406 Funeral deeth 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify: þ 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE OWNER other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked offiteny injury or other traumatic avent, sonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **BROWN** WEISS EVA ISIDORE 19a. Informant's Name/Relationship (Type, Print)
JOAN WETSS
JOAN ROSS / DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 JOSHUA COURT - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State TIFERETH ISRAEL CEM. 2/17/2004 ROSEDALE, MD 4 ☐ Donaylon 5 ☐ Other (Specify) 21. Signature Fun to Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Myer 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 MINULL 23a. Parts. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** weeks A Speratur /Medical Due to (or as a consequence of): Esophogen dephotility **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) physicien Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð Cardiovaranton 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 ₩o 1 ☐ Yes 2 ☐ No ei or Attending Physician: T s after death. si Director: After this certificat ed in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ⊟Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
6569 NORTH CHARLES ST ATIL 01 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 9 2004 Registrar

			1 - For State Registrar	State	of Marylar	nd / Depa <i>Cer</i>	irtment o	of He	ealth an <i>eath</i>	d Menta	l Hygien	e 20	04	05216
	- to-	HE.	1. Decedent's Name (First, Middle	Last)							of Death	-	Vaaa	3. Time of Death
	Physici /Medic		Josephine Yane				Feri		ay L <b>7.</b>	Yeer 2004	4:10 <sup>ам</sup>			
	Examin		4a. Facility Name (If not institution, give street and number)						ocation of C	Death	4	c. County		
9.		4	Millennium Healt	:h&Rehab	Center				: City			How		
#	Funeral			6. Sex 1 ☐ M 2 <b>]</b> ∑F	7. Age (In yrs.		If Under 1 Y Months Da	ear ays	If Under 24 Hours	Min. (Mor	of Birth hth, Dey, Yea		9. Birthple Count	ece (State or Foreign ry)
	Director	}	173-18-0257 Usual Residence of Decedent		85	Yrs.				5/2	21/1918	3	Penns	ylvania
	and w	1	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10	d. Inside City Limits
	Mary f sho	ō	MD Hov	vard	E	llicot	=							1 ☐ Yes 2½ No
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	3a or	Funeral Director	3004 N.Ridge Ro	1.			21	.043	R			USA		
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7	Hygie ther I	ပိ	12 17. Father's Name (First, Middle, I	.ast)				1	8. Mother's	Name (First, I	Middle, Maide	n Sumam	θ)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic avant, the Madical Extrinitor main for notified at once.	o Be	John Depta						_	usan I			-,	
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Division of	ul or Attending after death. I Director: After I in by the fune	flca	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Plac	e of Injury - At h	ome, farm, stre	et, factory, off	fice		28f. Loca	ation (Street a	nd Numbe	or Or Rural	Route Number,
á	al or	Certification:	4  Homicide	build	ding, etc. (Specii	<b>(y</b> )				City	Location (Street and Number or Rural Route Number, City or Town, State)			
<b>Y</b>	To the Hospital or Attending Ph within 24 hours after death to the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the	e best of my kno basis of examina nner stated.	owledge, death ation and/or inv	occurred at threstigation, in r	ne time, my opir	, date and p	place, and due occurred at the	to the cause( time, date ar	s) and mar nd place, a	nner as sta nd due to t	ted. he cause(s)
	To the within ? To the	Me	29b. Signature and title of certifier	WING HILL			29c. Li	cense r	number		29d. D	ate signed	(Month, D	ay, Year)
	-> H O		> 60	and			D	31	064	1	Fe	hrua	nu	18 2004
	0,		30. Name and address of person v	vho completed cau	ise of death (Iter	п 23а) (Туре,	Print) .	0	2	1	1.0	,,, v.	0,,	Mrs Mayles
	\		Kamesh 5	abapa	ilhi &	201-10	19 150	ack	CKIVE	- NEC	KKOO	cd 13	palh	Mrs Nougher
	Sta		31. Date filed (Month, Day, Year)	132.	Registrar's Signa	ature Ann	rela!							
	Registr	ar	TTR 1 9 2004	party and		Popula	- 11 m							

			For	State of Marylan	d / Depa	artment of H	lealth and	Mental Hyg	iene 2001.	05217
_			Registra Amended 4a	per dr./t1v2/4	./04 <i>Cei</i>	rtificate of	Death	2. Date of Dear	eg. No. 2004	3, Time of Death
П	Physicia		1. Decedent's Name (First, Middle,	Ann Ambus	6			Month	Day Year	101711
	/Medic	al	Margaret			4b. City, Town, o	r Location of Dea	18.1	4c. County of Death	7
	Examin	er	4a. Facility Name (If not institution.) Frederick		al	Freder	rick		Frederi	ck
	Funeral		5. Social Security Number	S. Sex , 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hi			nplace (State or Foreign
	Director		216-14-6782	10 M 20 F 94	Yrs.	MOIIIIS Days	110dis 1411	Feb 22	,1909	Md.
	pu ,	-	Usual Residence of Decedent  10a. State 10b. County	10c Cit	ty, Town or Lo	ncation			,	10d. Inside City Limits
	shon	5		1	uckt	estown				1 Nes 2 No
	ith the Marylan or 28a-f show	ect	10e. Street and Number		1	10f. Zip Code		1	0g. Citizen of What Cou	untry?
	23a or		4413 Buck	ceystown 1	IKT.	_	202		V.S.	A.
	ms 2:	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H	Hispanic Origin?	Specify Yes or No-	14. Race - Amer Black, White	
ပ္	or Ita	T.	1 Never Married 2 Marrie		i	1 Yes 2 No		nio moun, dian	Specify: 31	/
21215-0036	within 72 hours after death with the Maryland ene. then 'neturel', or items 23e or 28e-f ehow he Medical Examiner must be indiffied at	d by	3 → Widowed 4 □ Divorced	Year or Dates:					16b. Kind of Business/I	
15	n 72 l	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w	orking	Private	•
12	filed withii Hygiene. other than	дшо	Elementary/Secondary (0-12)	College (1-4or 5+)	Don	restic			Fumilie	
	Hygi other	Be C	17. Father's Name (First, Middle, L.	ast)			18. Mother's N	ame (First, Middle,	Maiden Sumame)	
lan	should be filed withir or Mental Hygiene. marked other than metlc event, the Mental than the Mental covert.	To B	Harry Off	-477			CARA	UE P	tack	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho many injury or other traumatic event, the Medical Examinatorials by notified at once.		19a. Inform Name/Relationshi	ush Sr. (Son)	19b. Maili	ng Address (Street	and Number or	1. 12 1	r. City or Town, State, Z	
- 80	and 3		Payet. Amb		613	Hung 1	oc pr	Date Date	20c. Location - City or	Mel ZITOZ
O	Pages 1 al nent of Hea int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		cemetery, crei	osition (Name of matory or other pla	ce) -			/ /
Baltimore	t. Pa ntmen ntent: njury		* 4 □ Donation 5 □ Other (Sp. 21. Signatus of Funeral Service L		stnav	en Min	7, Q1,	TAN 30,0)	Weden	oc my
Bal	permit. Pages Department of t Important: If Ite any injury or of		MIM V	leller	4	MY 4.	our.	runeva	el Hore	01
1			23a. Part1. Enter the disease, or o shock, or heart failure. List o	mplications that caused the deal	th. Do not en	ter the mode of dyl	ng, such as card	ac or respiratory arr	est,	Approximate Interval Between
18	Dhysisian		Immediate Cause (Final	fly one cause on each line.	m .					Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	quence of):					minutes.
	Examiner		Conventiable lies conditions	b						
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	quence of):					
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	nuence of):					
8760,	ate be executed hysician and the burial-transit		,	Dus 10 (0) as a conseq	4461106 01).				1	
687	phys phys s the	edical		d						
χ θ	death certificate e attending phys d for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of deli	very
Box	death a atter d for u	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		□Ectopic pregnand □ Other (specify) _	y 		Month	Day Year
P.O.	at the de by the	hys	9 Unknown	9L Unknown					1	
	The law requires that the ate bas been signed by th bage 2 should be detache	by P	Part II. Other significant condition	as contributing to death but not res	) A	. 1	1	\	bacco use contribute to	
Vital Records,	w require been sign		Hypertensive	Cardievascul	Law Ar	te7 losely	eroted	sca 1□Y	es 2 No 3 Pro	obably 4 2 dinknown
ecc	e law r has be je 2 sh	Completed						24a. Was a autop	sy prior to d	topsy findings available completion of cause of
==		Con						perfor 1 ☐ Yes		2 No
Vita	Attanding Physician: Th r death. ector: After this cartificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott	hor	eath (Check only or		
of	Phys this ral dir	. To	1  Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time of	III JUDA	4 C IAGISHI	-	ence 6 Other (Specow injury occurred	cify)
on	ding h. After funer	tion	1 □Natural 5 □ Pending 2 ☑Accident investig	(Month, Day Year)	Injury	Wo	rk? ]Yes 2. No	Fell in	drivewa	
Division	Attandi r death. octor: A by the fu	ifica	3 Suicide 6 Could n	OI DE 200 Place of Injune. At h	nome, farm, st				treet and Number or Ru	ra Route Number,
Ö	s afte	Certification:	4  Homicide	drive w				4413 BU	ckystown	PK HECKLICK
	Hospital or 4 hours afte Funaral Dir tely filled in I		29a. Certifier 1☐ Certifying (Check only 2 Medical E	g Physician: To the best of my kno Examiner: On the basis of examina	owled e, dea	th occurred at the t	ime, date and pla	ice, and due to the d	ause(s) and manner as	stated.
	To the Hospital or Attanovithin 24 hours after death To the Funaral Director: completely filled in by the	Medicai	one)	and manner stated.	and and a					
	To To	2	29b. Sign nul, and title of certifier	Solvar	7	29c. Licen	- 1		29d. Date signed (Montl	
			Millar	7 1000	60	D35			amory 28,	200.
	5		30. Name and address of person v	who completed cause of death (Iter	m 23a) (Type	Print)	+ Front	erich N	D 21701	
	· · · · ·	ate	31. Date filed (Month_Day_Year)	32. Registrar's Sign	nature .	1 -4	11160	- 1 VC , IV	0 0170	
1	Pogist		31. Date filed (Month, Day, Year)	4 2004 Almana	A	Crocke)				

			1 - For State Registrar	State of Marylar	nd / Depa	artment rtificate	of Hea	alth and I	Mental Hy	giene Reg. No.	004	05218
	Physici	an	Decedent's Name (First, Middle, Last)					lans	2. Date of De Month	aath Day	Year	3. Time of Death
	/Medi	cal	Aaron  4a. Facility Name (If not institution, give st	reat and number		4h City 3		cation of Death	repaul		3 2004 ounty of Death	
	Examir	ner	Johns Hopkins He					e City	•	70.0	ounty of Death	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. 33	last birthday) Yrs.	If Under Months	1 Year If	Under 24 Hrs. Hours Min.	8. Date of Bir Month Di 12/18	th 1970	9. Birth Cou Texa	place (State or Foreign intry) S
	pu 💌		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or Lo	ration					1	10d. Inside City Limits
	show and a	5	Maryland Frederick		urmont	Cation						1 ∑ Yes 2 □ No
	28a-1	rect	10e. Street and Number		drilloir c	10f. Zip	Code			10g. Citize	en of What Cou	intry?
	3a or	0	335 West Main Stre	et		217	788			U.S.	Α.	
	death	ner		2. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Deced	ent of Hispa	anic Origin? (S	pecify Yes or No o Rican, etc.)	0- 14	Race - Ameri	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mentat Hygiene.  If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medicial Examinar must be neitlied at	d by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2				i		white
5-0	natu dical	ete	15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted)</i>	16a. Dece (Give	kind of wor	l Occupation	n ng most of wor	king	16b. Kind	l of Business/Ir	ndustry
121	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Projec					Brown	ing Po	ols
d 2	buld be filed with Mental Hygiene. arked other than atic event, the	ပိ	17. Father's Name (First, Middle, Last)					. Mother's Nan	ne (First, Middle	1		
lan	lid be fental rked c	To Be	Harold Adams					Linda :	Bellow			
Maryland	2 should and Men is marker sumatic		19a. Informant's Name/Relationship (Typ		1				ral Route Numb		Town, State, Zi	p Code)
	1 and 2 Health em 27 i		Harold Adams - Fath		and the second section is			, Lumb	erton, 7		77657	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 sny injury or other once.		20a. Method of Disposition 1   Burial 2 □ Cremation 3   Re	moval from State	Place of Dispo cemetery, crer	natory or ot	her place)	i	Date		tion - City or T	
Ë	Emenition tant:		* 4 ☐ Donation 5 ☐ Other (Specify)	0ak	Bluff						Neches	
Bai	Departimbour in sny ir		21. Signature of Funeral Service License	no Allen					tauffer			
29. A. 71	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Fungal phe	th. Do not ent	er the mode	of dying, s	uch as cardiac	or respiratory a	ederic	k, Mary	Approximate Interval Between Onset and Death  Week
68760,	Examiner and burial-transit	dical Examiner	Sequentially list for Altions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a donsed Due to (or as a consed Due to (or as a consed	phocyh ence of).	ic lev	kemič					6 menths
P.O. Box 6	w requires that the death certifical been signed by the attending phy should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of of 9 Unknown	al death 3	Ectopic pre				230	d. Date of deliv	ery Day Year
	uires that n signed t	d by P	Part II. Other significant conditions cont	ributing to death but not res	sulting in the u	nderlying ca	use given ii	n Part I.		obacco use Yes 2 🗆		he cause of death? bably 4 Munknown
Records,	hysician: The law rec his certificate has bee I director, page 2 shou	Completed by	A						24a. Was auto perfo	psy ormed?	24b. Were auto prior to co death? 1 \sum Yes	opsy findings available ompletion of cause of
Vital		BeC	25. Was case referred to medical				26	6. Place of Dea	th (Check only		1 163	ZZINO
Į (	Physician: this certific ral director,	ToE	examiner? 1 ☐ Yes 2 🔀 No	spital: 1 kInpatient 2	ER/Outpatier	nt 3□ DO.	A Other:	4 🗌 Nursing H	ome 5 Resi	dence 6 [	Other (Speci	fy)
Division of	0 - 0	Certification:	27. Manner of Death  1 ⊠ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	3c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe	how injury o	occurred	
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, factory,	, office		28f. Location ( City or To		Number or Run	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in I	Medical		cian: To the best of my known:  On the basis of examination and manner stated.								
	with To t	Σ	29b. Signature and title of certifier			29c.	License nu				signed (Month,	
			malle	MD MD			RES	5 - 000		tebru	sary 3	, 2004
	5		30. Name and address of person who con				10-		.0 0	0 11		1 1
12.	4 2 0	ato	31. Date filed (Month, Day, Year)	Johns Hopki	ns Host	pital	600 1	North Wa	lite Street	, balt	more, M	lary land 2128
9	Sta Regist	ate rar	FEB 0 5 2		A	Local	60					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:400M ROBERT LEE ANDERSON MNUARY 39 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors' Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1⊠M 2□F July 9, 97 1906 Mississippi Director 416-01-8716 Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits show rel', or Items 23e or 28a-f shov Examiner must be notified at 1X Yes 2 □ No Maryland Prince Goerge's Riverdale Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6108 63rd Place 20737 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 15 Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced 1945 Year or Dates "naturel", Completed 16b. Kind of Business/Industry other treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Voucher Examiner Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be John Anderson E11a Foster ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12325 Quiet Owl Lane, Bowie, Maryland 20720 Phyllis L. Anderson/Daughter Important: If item 27 any injury or other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 02/06/2004 Brentwood, Maryland \* 4 □Donation 5 □ Other (Specify) permit, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FORT LINCOLN FUNERAL HOME Nancu 3401 Bladensburg Road, Brentwood, Maryland 20722 ecen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** reumona resulting in death) /Medical Due to (or as a consequence of): **Examiner** 6 Sequentially list conditions Due to for as a consequence of Examiner r any, leading to immediate cause. Enter Underlying Cause (Disease or injury death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physician a hed for use as the burial-Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 D Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page certificate 1□ Yes 2 [] No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1 No 1 Unpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending 1 Naturai Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after to the Funerel Direct 4 Homicide Hospitel 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WITE 351-LAUREUMD 15 AL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 3 2004 Registrar

DHMH 17 Rev 1/2001

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W 2121

Maryland

Baltimore,

Box 68760,

		1 - For State Registrar	State of Ma	aryland /	Cei	rtificate of	Death		Reg. No	2001	
Physicia /Medica		Decedent's Name (First, Middle, Last     Violet	Ma	У	At:	herton		2. Date of D Month 1	Da Da	y Year 04	3. Time of Death
Examine Funeral Director		4a. Facility Name (If not institution, give 9600 Caltor La 5. Social Security Number 212-13-8078	ne	e (In yrs. last b	<i>irthday)</i> Yrs.	,	Washing  If Under 24 Hr  Hours Mir	gton s. 8. Date of B	I	9. Bir	th  George's  thplace (State or Foreign buntry)  anama
	or.	Usual Residence of Decedent  10a. State 10b. County		10c. City, To				0.4		ΤΨ Ι ζ	10d. Inside City Limits 1 X Yes 2 □ No
with the M 3a or 28a-f	i Director	MD P.  10e. Street and Number  9600 Caltor La		Ft. V	Nas.	hington 10f. Zip Code 207	44		10g. Cir	tizen of What Co	ountry?
urs a	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cub 1 X Yes 2 □ No		Specify Yes or North Rican, etc.)	10-	14. Race - Ame Black, Whit Specify: B1	e, etc.
Aithin he.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w d)			and of Business	
tal H dott	To Be Co	17. Father's Name (First, Middle, Last) Ralph Clark	· · · · · · · · · · · · · · · · · · ·				18. Mother's Na	ame (First, Middle rah Ev	e, Maider ans	Sumame)	
C = 14 F		19a. Informant's Name/Relationship (T. Gloria Dunlap-I	•	20b. Place	960 of Dispo	sition (Name of	or Ln.,		ashi		MD 20744
Page Page Thent o Bint: # ury or		1 XBurial 2 ☐ Cremation 3 ☐ I     4 ☐ Donation 5 ☐ Other (Specify,  21. Signature of Funeral Service License		cemet	ary, crar ning	gton Nat	:'1 <sup>2-</sup>	3-04	Sui	tland,	
permit. Departi		23a. Part1. Enterthe disease, or comp shock, or heart failure. List only of	lications that caused	the death. Do	WI	Home Inc	c. 2504	28th	St./	, N.E.	, WDC20018 Approximate Interval Between
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Rej	nal Fa	of):						Onset and Death
executed en and rial-transit	il Examiner	Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as o	rdiomy abete a consequence	Mel						
death certifi e attending od for use as	Physician/Medical	d									ivery Day Year
	þ	Part II. Other significant conditions co	ntributing to death bu	ut not resulting	in the u	nderlying cause giv	ven in Part I.		tobacco	_	o the cause of death?
The law require pate has been sipage 2 should I	Completed							per	s an opsy formed? 2 <b>X</b> No	prior to death?	utopsy findings available completion of cause of
hyaicii this cer	tion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day	y 28b.	utpatier Time o Injury	28c. Injur	ner: 4 🗆 Nursing	Home 5 X Res 28d. Describe	sidence		cify)
ital or Attendi its after death. ral Director: A led in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc		arm, str	eet, factory, office			(Street ar own, State		ural Route Number,
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	rsician: To the best of iner: On the basis of and manner sta	examination a	ge, deat nd/or in	occurred at the tilvestigation, in my c	opinion, death occ	ce, and due to the curred at the time	, date and	) and manner as d place, and due te signed (Mont	e to the cause(s)
T wit		230. Signature 3 di litera de l'inicia	BO	2 m	0		16646			_	3, 2004
Stat Registra		30. Name and address of payson who of the state of the st			1-0	ld Bran	ch Ave	. Clint	on 1	Md 207	35

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Feb 2004 12:25P M /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2X F Yrs. Director 107-40-6593 53 Sept 13, 1950N. Carolina Usual Residence of Decedent f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at MD Montgomery Olney 1 XYes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 17907 Shotley Bridge Place 20832 United States America Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after al Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Black þ 3 Divorced traumatic event, the Medical 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet College (1-4or 5+) Elementary/Secondary (0-12) Nurse Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o Clinton Boone Annie Mae Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) China O. Adams -Daughter 17907 Shotley Bridge Place, Olney MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 02/07/2004 Washington, D.C. Funeral Service Licersae 21. Signatus 22. Name and Address of Facility Robert O. Freeman Funeral Svc Bny enar 1353 H Street, N.E. WDC 20002 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTRAABDOMINAL SEPSIS Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-trag Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ å 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2√2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 X Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) MV 10 completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Silver Spung MD andice 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2004 Registrar

Dhori	7	1 - For Rate Amend Item #5  1. Decedent's Name (First, Middle, Last,					2. Date of De	Reg. No. aath Day	Year	3. Time of Death		
Physici /Medic		BERTHA LOUISE A					2	1	2004	5:45 A <sup>M</sup>		
Examir	er	4a. Facility Name (If not institution, give DOCTOR S HOSPITA			LAN			PRI	County of Deeth			
uneral irector		397-30-7301	7. Age (1) 78	In yrs. last birthday) Yrs.	If Under 1 Months			av Year)	Coun	lace (State or Foreign try) h Carolina		
Mila		Usual Residence of Decedent  10a. State  10b. County	1	0c. City, Town or Lo	cation			10d. Inside (				
nutilised at	tor	MD PRINCE GI	EORGE'S	BLADENSE	BURG					1 Yes 2 □ No		
	Funeral Director	10e. Street and Number 5999 EMERSON STREI	ET # 601		10f. Zip ( 2071			10g. Citizen of What Country? U.S.A.				
	by Funer	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:			ent of Hispanic Origin? fy Cuban, Mexican, Pue No Specify:	(Specify Yes or No erto Rican, etc.)		4. Race - Americ Black, White, Specify: B			
T I		15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	dent's Usual	Occupation	porking.	dustry				
Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	CLEH		k done during most of war retired)	OT NET G	PRT	PRIVATE			
E E		12th 17. Father's Name (First, Middle, Last)		CLEI		18. Mother's N	ame (First, Middle	Maiden Sumame)				
,	To Be	UNKNOWN	. ROSS									
ar traumatic event, Ibs M		19a. Informant's Name/Relationship (T) PATRICIA JONES/DAU	er, City or IE, M	Town, State, Zip ARYLAND	20721							
i cilia		20a. Method of Disposition 1   ↑ Burial 2 □ Cremation 3 □ F	20c. Location - City or Town, State									
		* 4 □ Donation 5 □ Other (Specify)		Landover,Maryland nkins Funeral Home								
any injury or conce.		21. Signature of Funa al Service Licens	86			Landover k						
cian dical niner	er	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	errest,	-	Approximate Interval Between Onset and Death							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 5 No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	Ectopic pre Other (spe			23	3d. Date of delive Month	nry Day Year		
should be detached		Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying ca	use given in Part I.		tobacco us		ee cause of death? ably 4 □Unknown		
V	Completed	Mype	rtansiu	re Heu	ert	Discon	24a. Was auto perfe		prior to cor death?	psy findings available inpletion of cause of 2 No		
olrector, page	Be	25. Was case referred to medical examiner?	Hospital:		<del></del>		eath (Check only					
os .	1: To	1 Yes 25 No 27. Manner of Death	1 1 Inpatient				Home 5 Res			/)		
	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day )	(ear) Injury	М	Sc. Injury at Work? 1 Yes 2 No			Number or Rura	I Route Number		
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maren	Medical			xamination and/or in		at the time, date and pla in my opinion, death oc						
Ē	Σ	29b. Signature and title of certifier	1-1			License number	7 -		signed (Month,			
8		D24095 02-02										
3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pragna B Pate 1- MD-5632 Annapolis Road # 11 Bladensb  Pragna B Pate 1- MD-5632 Annapolis										

			For State Registrar	State o	f Maryland / Do	epartment of Certificate of	Health an Death	nd Mental Hy	giene 20 (	04 05223					
			1. Decedent's Name (First, Middle,	Last)				2. Date of De		3. Time of Death					
	Physici /Medic		Elizabe	eth Mary	Bass				y 30, 200						
}	Examin		4a. Facility Name (If not institution,				or Location of D	Death	4c. County of						
			Shady Grove Adv			Rockv:		Hrs   0 Date of Bir		gomery					
	Funeral		,	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs. last birth	Months Day		Min. 8. Date of Bir (Month, Da Oct. 2	9, 1917	9. Birthplace (State or Foreign Country) New Jersey					
	Director		577-18-0244 Usual Residence of Decedent		00			000. 2	J, 1J17 1	new sersey					
	yland		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits					
	a-f sl	ctor	Maryland Montg	omery	Gaithe	ersburg				12∑Yes 2 ☐ No					
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh						
	ath w	rai	17060 King Jam		#908		20878	2/2 7 7	U.S.A						
	Rams Itams	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Fo		If Yes, specify Cu	Hispanic Origin ban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	Black,	- American Indian, , White, etc.					
36	itied within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23s or 28s-f show that the Mudical Evaluar must be notified at	by Funerai	3 ☑ Widowed 4 ☐ Divorced	If Yes, Gr Year or D	ve	1 ☐ Yes 2 🔀 N	o Specity:		Specify:	White					
ð	2 hou		15. Decedent			Decedent's Usual Occ		functing	16b. Kind of Bus	iness/Industry					
215	e n n	ple	(Specify only highest Elementary/Secondary (0-12)	College (		Give kind of work don life. DO NOT use reti	ed)	Working							
2	od wil	Completed		2	I	Homemaker				Home					
Maryland 21215-0036	tal H d oth	Be	17. Father's Name (First, Middle, L					Name (First, Middle lizabeth		)					
2	J Men J Men	ပ္	Anthony Stanl  19a. Informant's Name/Relationsh		10h	Mailing Address (Stre			oute Number, City or Town, State, Zip Code)						
Mai	d 2 sl th and 17 ls r traur		Charles S. Poch	_		99 Timber				Maryland					
	Heal Heal tem 2		20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other p	1	Date		City or Town, State					
ē	Pages ent of nt: # i		1 ☐ Burial 2 🖾 Cremation  4 ☐ Denstion = 5 ☐ Other (Sp		State			m 2/1/0/	Alexandr	ia Vircinia					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or Items 23s or 28s-1 show any injury or other traumatic event, the Mudical Examination in all the notified at once.		*4 Departion 5 Other (Specify)  Metropolitan Crematorium 2/1/04 Alexandria, Virgi  21. Signature of Funeral Service Licensee  Olin L. Molesworth P.A., Funeral Home												
m,	Depar Impor		Korert L.	Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland and Little Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
3			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that only one cause on	caused the death. Do no	ot enter the mode of d	ying, such as ca	rdiac or respiratory a	rrest,	IIII AU DOLMOOLI					
	Physician		Immediate Cause (Final disease or condition	, ac	ate m	7000	dial 1	nda-c	Man	Onset and Death					
П	/Medical Examiner		resulting in death)	Due to	(or as a consequence of	():									
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Вох	death certific e attending pl id for use as (	an/	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregnancy birth 2 Tetal death	3 □Ectopic pregnar	псу		23d. Date Mont	of delivery th Day Year					
	D 00 D	sici	1 Yes 2 No	4□Preg 9□Unkr	nant at time of death lown	5 ☐ Other (specify)									
P.O.	that the de led by the detached		Part II. Other significant condition	ns contributing to d	leath but not resulting in	the underlying cause	given in Part I.	23e. Did t	tobacco use contrib	oute to the cause of death?					
ds,	uires tha signed Id be det	d by	14-100	IN) YO	14111			1 🗆	Yes 2000 3	3 ☐ Probably 4 ☐ Unknown					
COL	law requires as been sign 2 should be	iete	~ e ra	1	Northici	enin		24a. Was	an 24b. W	ere autopsy findings available for to completion of cause of					
Re	0 5 0	ompieted						auto perfo	ormed? de	ior to completion of cause of eath?  ☐ Yes 2☐ No					
ital	ician: Th certificate rector, pag	e C	25. Was case referred to medical				26. Place of	Death (Check only		2103 ELINO					
<u> </u>	S S	ToB	examiner? 1 ☐ Yes 2 ⊠No	Hospital: 1 🗆	Inpatient 2 XER/Out	patient 3□ DOA	other: 4 🗆 Nursi	ing Home 5 ☐ Resi	dence 6 Other	(Specify)					
n 0	ding Ph n. After th funeral		27. Manner of Death  1X Natural 5 ☐ Pending	28a. Date (Mor		jury W	ork?		how injury occurred	d					
sio	Attending r death. ector: After y the fune	cati	2 Accident investig	ation			☐ Yes 2 ☐ No		Charles and Misself	and Owner Davids Marshau					
Division of Vital Records,	l or Atten after deatl Director:	ertification;	4 Homicide determine	286. Plac	e of Injury - At home, fare ling, etc. (Specify)	m, street, factory, offic	e	City or To		r or Rural Route Number,					
ш	Hospital or 24 hours afte Funeral Dir 1ely filled in I	O	29a. Certifier 1 Certifyin	Physician: To th	e best of my knowledge,	death occurred at the	time, date and t	place, and due to the	cause(s) and man	ner as stated.					
	To the Hospital or Attending Ph within 24 hours after death. To tha Funeral Director: After th completely filled in by the funeral	edical		examiner: On the b	pasis of examination and nner stated.										
	To the Hospital within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier	1 w h		29c. Lice	nse number		29d. Date signed	(Month, Day, Year)					
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	~		30. Name and address of person		- t	Type, Print)		G.fcm		1					
	Ç.		31. Date filed (Month, Day, Year)	1111	Registrati's Signature	Fa1 171	116	G (ca)	, WD	208 14					
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05224 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 3, 2004 Feb. Physician 2:30 AM J. PATRICIA BREWER /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Salisbury Nursing and Rehab Center Salisbury, Md. Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 2-5-1930 Birthplace (State or Foreign Country)
 NEW YORK 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days Hours 1□M 2♥F 73 Yrs Director 577-48-6813 Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Funeral Director SUSSEX MILLVILLE DELAWARE 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health end Mentel Hygiene. ò 632 BRIDGE LANE - WHITE'S CREEK MNR US 19967 or items 23a 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No 1 ☐ Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 X No Specify WHITE Specify: Be Completed by 3 Widowed 4 Divorced Year or Dates "naturai". 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NONE 4 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VIRGINIA HARDY HAROLD FEELY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 632 BRIDGE LN., WHITE'S CREEK MANOR, MILLVILLE, DE. Depertment of Health inportant: If item 27 is any injury or other tra THOMAS B. BREWER/ HUSBAND Baltimore, 20c. Location - City or Town, Stat 19967 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Cher (Specify) GATE OF HEAVEN CEMETERY 2-7-04 DAGSBORO, DELAWARE 21. Signature of Funeral Se 22 Name and Address of Facility
MELSON FUNERAL SERVICES, LID. WEST AVE, OCEAN VIEW, DE. 19970 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disea shock, or heart failure **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examine Due to (or as a consequence of): Physician/Medical Examiner eng or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. be detached 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed funeral director, page 2 should completion of cause of deeth? 2 12 No 1 ☐ Yes 2 ☐ No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 

Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Haturel 5 Pending 1 ☐ Yes 2 ☐ No efter death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗆 Homicide within 24 hours of To the Funeral I To the Hospital edicai 1 Certifying Phyeiclan: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled. (Check only one 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifier ens

State

DHMH 16 Rev 6/95

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PRICIA

Registrar FEB 0 6 2004

31. Date filed (Month, Day, Year)

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. Repistrer's Signature

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

1346 S. Division St. Suite, Salisbury, Md. 21804

State of Maryland / Department of Health and Mental Hygiene 2004 05225 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 2,2004 **Physician** 9:15 PM Edythe C. Baumgartner /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Williamsport Williamsport Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 8, 1903 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** Months Days Hours 1□M 2ÅF 579-14-3718 100 Yrs. Tennéssee Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Williamsport Director Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 154 North Artizan Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 21215-0020 Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is merked other than any Injury or other trsumatic event, the M Retail Dept. Store Sales Clerk 12 **Baltimore, Maryland** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Victoria Quarles Lawrence Brown Cordell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 358 N. Timber Tribe Mineral, VA 23117 Paul C. Baumgartner/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-11-04 Arlington, Virginia Arlington National Cem. 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Servi Servi 425 S.Conococheague St. Williamsport, Mu 21795 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or lear failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) BUDDER /Medical 3 MONTHS Examiner Examiner anding physician and use es the bunal-trensit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes 2 □ No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1\_ Yes 22010 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident efter death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital of within 24 hours of To the Funeral Completely filled edical 29a. Certifier 🕊 Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5570 telanuary 3, 2004 545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 154 N. AKZTIZANST. 21795 WILLIAMAPORT MD Howe 31. Date filed (Month: Pay) 32. Registrar's Signature 2004 State Registrar

DHMH 16 Rev 6/95

		1 - For State of Maryland / Dep	artment of Health and Nartificate of Death	Mental Hygier	ne 2004	05226			
Physic	ian	Decedent's Name (First, Middle, Last)     NAOMI LOUISE BENNETT		2. Date of Death Month	Day Year	3. Time of Death			
/Med Exami	ical	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JANUARY	RY 27,2004 910AM 4c. County of Death				
Exami	ner	MEADOW RIDGE HOUSE	COLUMBIA		HOWARD				
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 214–20–7875 1 M 2 F 86 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	(Month, Day, Yea	ar)   Country	•			
Director		214-20-7875 The State of December 1 The State of State of December 1 The State of St		SEPT. 8,	1917 MAR	YLAND			
irylanc show	_	10a. State 10b. County 10c. City, Town or L	ocation		100	1. Inside City Limits			
the Mz	ecto	MARYLAND CARROLL HAMPSTE	AD 10f. Zip Code	100 /	Citizen of What Country	1  ¥es 2  No			
3e or	i Dir	4210 CRYSTAL COURT 2B	21074	1	NITED STATE				
within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Medical Examinar must be rediffed at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Black, White, et				
s after	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ▼No Specify:		Specify: WHIT				
2 hour	ted k	15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b.	. Kind of Business/Indu				
ithin 7 ne. "n	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	KING	DVME@mi	r.C			
filed w Hygier other th	Ö	8 17. Father's Name (First, Middle, Last)	HOMEMAKER  18. Mother's Nam	DOMESTIC  Name (First, Middle, Maiden Surname)					
id be in ental in eva	To Be	CHARLES L. MICHAELIS	ALMA H		,				
d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 7 is marked other than "natural", or Itams 23e or 28e-1 show traumatic event, It o Modical Examiner must be indiffied at	-		ing Address (Street and Number or Ru						
s 1 and 2 f Health itam 27 other tr		DENNIS C. BENNETT/SON 421  20a. Method of Disposition 20b. Place of Disp	0 CRYSTAL COURT 21		EAD, MD 210  Location - City or Town				
permit. Pages 1 and Department of Heali Important: If itam 2 eny injury or other once.		1 Rurial 2 Cremation 3 Removal from State	amatory or other place)		ALTIMORE, M	_			
permit. P Departme Importan eny injuri		4 Donation 6 Donat (Specify)	2. Name and Address of Facility YERS—DURBORAW FUNI						
Per Co		Justin K. Durban	91 WILLIS STREET,	WESTMINST	ER, MD 21	157			
Physician /Medica Examinei		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):	1 -1	or respiratory arrest,	lr G	opproximate nterval Between Onset and Death			
icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, any learning immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):							
The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month D	ay Year			
quires that n signed b		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	ouse contribute to the	1			
The law requir ate has been si page 2 should	Completed			24a. Was an autopsy performed	prior to comp death?	y findings available iletion of cause of			
ician: certific ector,	Be	25. Was case referred to medical examiner?  Hospital:	Othor	th (Check only one)	Assiste	d Crois			
ding Phys h. After this funeral dir	tion: To	27. Magner of Death  Natural 5 Pending	ant 3 DOA 4 Nursing H	ome 5 Residence 28d. Describe how in		1			
To the Hospital or Attending Physician: The within 24 hours after death.  To tha Funarel Diractor: After this certificate ha completely filled in by the funeral director, page	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Street City or Town, Sta	and Number or Rural F ate)	Route Number,			
he Hospit: n 24 hours ha Funare	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal of the best of my k							
Within Comp	×	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month, Da	y, Year)			
W4		30. Name and address of person who completed cause of death (Item 23a) (Type 1.0.), 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0., 1.0.,	DEMARKENCE NE	Colowha	in, MD 2	1044			
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	State of Maryland / Department of Health and Mental Hygiene 2001.	1

Physician /Medical Examiner	Decedent's Name (First, Middle, Last)     DANNIE WAYNE BLIM	2. Da									
Δ	DAMNIE MAINE DUIL	ISON JA	onth Day 2004	3. Time of Death  1218 P M							
	4a. Fecility Name (If not institution, give street and number) 305 CRESTVIEW COURT	4b. City, Town, or Location of Death WESTMINSTER	4c. County of Death CARROLL								
Funeral Director	5. Social Security Number 220-52-4900  Usual Residence of Decedent  6. Sex 1 M 2 F  7. Age (In yrs. last birth	H Under 1 Year   H Under 24 Hrs.   8. Da	ate of Birth 9. Birth Counth, Day, Year) 9. NORT	plece (State or Foreign Intry) H CAROLINA							
Maryland a-f show illiad at	10a. State 10b. County 10c. City, Town	or Location MINSTER		10d. Inside City Limits 1 Yes 2 □ No							
Sitter death with the Mainten as 28 or 288-1 solicer must be notified Properties. Funeral Director	10e. Street and Number 305 CRESTVIEW COURT	10f. Zip Code 21158	10g. Citizen of What Cou								
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23s or 28s-1 show ant, the Modical Examinar must be notified at a Completed by Funeral Director		13. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 No Specify:									
Maryland 21215-0036 to 2 should be filed within 72 hours att the and Mental Hygiene. 27 is marked other than "natural", or retraumatic event, the Medical Exercit To Be Completed by F	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	lecedent's Usual Occupation Give kind of work done during most of working ife. DO NOT use retired) RK LIFT OPERATOR	16b. Kind of Business/li								
	TOHN WINTERS		t, Middle, Maiden Sumame) BARNHILL								
Baltimore, Marylan permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic sv once.	19a. Informant's Name/Relationship (Type, Print)  CAROLYN J. BLINSON - WIFE 80	Mailing Address (Street and Number or Rural Rout  O CROWS CT., APT. 1F	B, WESTMINSTER	, MD.21158							
Baltimore, semit. Pages 1 ar Department of Hea Mportant: If Item: any injury or other page.	1 Burial 2X Cremation 3 Removal from State ALL CO	Date crematory or other place) UNTY CREMATION 2/2/  22. Name and Address of Facility FLETC		E, MD.							
Departiment in portion and in portio	21. Signature of Funeral Service Licenses	254 E. MAIN ST., W	ESTMINSTER, M								
Pnysician /Medical	23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atheroscleratic Cardio Card										
executed executed in and institutions its transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events c.	):									
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Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has seen signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delin	very Day Year							
w requires that we require state that sen signed be should be detailed by PP		he underlying cause given in Part I. 2	3e. Did tobacco use contribute to 1 ☐ Yes 2 ☐ No 3 ☐ Pro	J							
Vital Record  ulcian: The law requir  certificate has teen s  rector, page 2 should			4a. Was an autopsy performed?  Yes 2 \( \sum \) No 1 \( \sum \) Yes	topsy findings available completion of cause of							
Division of Vital Rewithin 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	examiner?  1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Out		ack only one)  5 Residence 6 ** Other (Special Control of the Cont	Ty) AT SCENE							
Division c rs after dath. rs after dath. el Director: Alfer t ed in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify)	n, street, factory, office 28f. Lo	ocation (Street and Number or Ru lity or Town, State)	ral Route Number,							
the Hospita thin 24 hours the Funerel impletely fille		or investigation, in my opinion, death occurred at	the time, date and place, and due	to the cause(s)							
To use the company of	I him in. D	29c. License number O.C.M.E	29d. Date signed (Month FEB. 1,	n, Day, Year) 2004							
4		Penn Street, Baltimore	, Maryland 21201								
State Registrar		Coul s									

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2004 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle, Last) Month **Physician** January 11, 2004 4:35 Berthenia J. Boone /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F 1928 Director 242 32 1123 May 14, North Carolina Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show treet must be notified at MD Prince Georges Capital Heights 1X Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 607 Cappy Avenue 20743 United States Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status The Mudical Examination Baltimore, Maryland 21215-0036
Depmil. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Importent: If Item 27 is marked other than "natural", or Item any injury or other treumatic event, Ite Modified Examinations. filed within 72 hours after 1 ∐Yes 2⊠No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black ۾ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Government Elementary/Secondary (0-12) College (1-4or 5+) 8th none Clerk Census Bureau 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Wilbur Boney Rebecca Jacobs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 607 Cappy Avenue, Capital Heights, MD Daughter Sylvia Boone 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Riverdale Crematory 01/16/04 Riverdale, Maryland 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility John T. Rhines Funeral Home 21. Signature of Funeral Service Licens 3015 12th St., NE Washington, DC 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Septicemia /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Gastro Intestinal Bleed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Anemia IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 No 9 Unknown 9 Unknown ል signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ End Stage Renal Disease, Shock Liver, Diabetes, 1 Yes 2X No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has bairector, page 2 s Hypertension autopsy perform 1 Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ After thi funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 5 Pending investigation Injury 1 XNatural 1 ☐ Yes 2 ☐ No death. s after death.

I Director: A id in by the fu 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours aff To the Funeral Discompletely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 60619 January 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20910 Connie Le 1500 Forest Glen Road, Silver Spring, MD 31. Date filed (Month, Day, Year) Registrar's Signature FEB 0 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar 05229 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 28 2004 January Shirlev Mae Barte1 1:25 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 11,1925 5. Social Security Number 9. Birthplace (State or Foreign Country) New York 6 Sev 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K 088-18-0677 78 Director Usual Residence of Decedent worle 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f ehov Exercitive nast be notified at 1 ▼ Yes 2 No Prince George's Bowie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3111 Teal Lane 20715 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Peges 1 and 2 should be filled within 72 hours after one of Health and Mental Hygiene.
nent of Health and Mental Hygiene.
nent if item 27 is marked other than "naturel, or Itel
nry or other traumatic event, Itta Mesical Euriling Black White etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Social Work 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jay Richardson ပ Isabelle Bean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Michael Bartel / Son 2668 Worrell Court Crofton. MD. 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2-3permit. Peges 1 Department of H Important: If ite any injury or ot 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Arlington National Cem. Arlington, VA. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Highway Bowie, Maryland 20715 54 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kenu Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) detached P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Tyes 20 No 1 🗌 Inpatient 3 DOA 2 ER/Outpatient To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Natural 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Z140/ Timothy Woods, M.D. medical Kun 31. Date filed (Month, Day, Year) 32. Registra Signature State 2004 Registrar FEB

			1 - For State Registrar	State of Maryla	Cei	rtificate of L	Death		Reg. No.	
	Physicia		1. Decedent's Name (First, Middle, Last) Terrell Marie Be					2. Date of Da Month Januar	Day Year	3. Time of Death 3:11 P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
			Fort Washington Ho			Fort Was	hington If Under 24 Hrs.	100.00	Prince Ge	eorge's
	Funeral Director		131 01 3132	7. Age (In y ] M 21⊠⊅€ 64	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bin (Month, De 08/30)	th y, Yeer) 9. Bi /1939	rthplace (State or Foreign Jountry) Texas
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Mary I-f sh	tor	Maryland Prince G	eorge's	Ft. Was	hington				1 ☐ Yes ½X No
	or 28s	Oirec	10e. Street and Number			10f. Zip Code	20744		10g. Citizen of What C	ountry?
	ath w	ral	12619 Tartan Lane		110			7 17 11		-i tadia
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married *** Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  total Yes 2 No 1 Yes, Give Year or Dates: 1 C	.967–	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2∰No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecry Yes or No Rican, etc.)	- 14. Race - Am Black, Wh Specify:	
ညှ	72 hou	ted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occupa		ina	16b. Kind of Business	s/Industry
21	ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Atto	DO NOT use retired)	)	ang .	Federal G	Sovernment
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au	Mental Mental arkad o	To Be	Terrell Fisher					L. Lown		
Maryland 21215-0036	and 2 should the salth and Ment of the salth and south of the salth salt	_	19a. Informant's Name/Relationship (Ty Robert A. Berkovs			,			er, City or Town, State, gton, Maryl	
Baltimore,	of Hee		20a. Method of Disposition 1 ☐ Burial 2 ★ Denation 3 ☐ F	20I	b. Place of Dispo cemetery, crer	sition (Neme of matory or other place	e)	Date	20c. Location - City o	Town, State
Ĕ	Pages ment of lant: If its jury or o		* 4 □Donation 5 □Other (Specify)	K	Calas Cr	ematory	02/01	1/2004	Edgewater,	Maryland
Ball	permit. Departm Importa any inju		21. Signature of Juneral Service Licens			. Name and Addres	George		as Funeral Hill. Marvl	
8			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the d ne cause on each line.	eath. Do not ent	er the mode of dying	, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Herron	charge	2º to	Keno	stype	0	30-60 min
	Examiner			Due to (or as a cons	sequence of):	A R				1/9-15
45 <sub>41</sub>	2/4	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of):	germ	<i>c</i> g		·,	10 1320
	ficate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Bonco	dere	o, sec	age I			years
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D. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a:	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
P.0.	that the ed by detac		Part II. Other significant conditions col	ntributing to death but not	resulting in the u	nderlying cause give	n in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
ds,	puires n sign ald be	Completed by	HTW					101	res 2□No 3×P	robably 4 Unknown
00	aw requir s been si 2 should l	piete						24a. Was		utopsy findings available
Ä	The lav ate has page 2	mo:						autop perfo 1 🗆 Yes	rmed? death?	completion of cause of s 2 2 No
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of	Attending Physician: r death. sctor: Atter this certifics by the tuneral director, I	- To	1 X Yes 2 ☐ No  27. Manner of Death	fospital: 1 ☐ Inpatient 2 28a. Date of Injury	2 X ER/Outpatier 28b. Time of		4   Nursing Ho		dence 6 Other (Spenow injury occurred	ecify)
OU	ding th. : Atter	ition	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year		Work	?	204. 900011901	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division of Vital Records,	Dirte o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str	eet, factory, office		28f. Location (5 City or Tox	Street and Number or R vn, State)	ural Route Number,
	Hospital or 24 hours atte 5 Funeral Dir etely tilled in I	edical C	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exami	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death unation and/or in	n occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	9 91 T	29d. Date signed (Mon	th, Dey, Year)
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1	_(10)		30. Name and address of person of co	omplet cause of death (	1.0. 0		iet Brown	ok Lo	Clinton "	10 20735
	Sta Registr		St. Date filed (Month Dey, Year) FFR 0 2 2004	32. Registrar's Si	gnature	<i>!</i> ,		-		

		,	1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I rtificate of	lealth and <i>Death</i>	Mental Hy	giene Reg. No. 2004	0523		
İ	Physici		1. Decedent's Name (First, Middle, Last)	rine Brand	1			2. Date of De Month January	Day Year	3. Time of Death 10:55 A.M.		
	/Medio Examin		4a. Facility Name (If not institution, give Southern Maryland Hos	street and number) pital Cente	er	C	or Location of Dea Linton	ath	4c. County of Death			
	Funeral Director		5. Social Security Number  577–54–6224  Usuel Residence of Decedent	7. Aç ]M 2∏∑F	ge (In yrs. last birthday, 64 Yrs.	Months Days	If Under 24 Hr Hours Min	8. Date of Bir (Month, Da December	th year) 9. Births Court 12, 1939 Wash	place (State or Foreign ntry) nington, D.C.		
	e Maryland 8a-f show	Director	10a. State 10b. County  Maryland Prince Geo	irge's	10c. City, Town or L	Lanh	em		10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
	with the		10e. Street and Number 7063 Palamar T	i m		10f. Zip Code	20706		10g. Citizen of What Could U.S.A.	ntry?		
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar rotat be multiled at	by Funeral	11. Marital Status  1 Never Married 2 W Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of If Yes, specify Cub	dispanic Origin? an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)		etc.		
Baltimore, Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "natur vent, Ine Modical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th grade	cation e completed) Coffege (1-4or	5+) (Give	dent's Usual Occup a kind of work done DO NOT use retire S <b>Driver</b>	during most of w	rorking	16b. Kind of Business/Indu  McLean Transpor			
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, Mary	and 2 should be eaith and Mental in 27 is marked one traumatic ever		19a. Informant's Name/Relationship (T) Sonja Harper (Daughter			ing Address (Street Palamar Ti			er, City or Town, State, Zip 20706	Code)		
imore	Pages 1 and of He and of Itam		20a. Method of Disposition  1 Structure of Funeral Service Licensee  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or cemetery, crematory or other place)  Lincoln Memorial Cemetery  21. Sunature of Funeral Service Licensee  22. Name and Address of Facility  23. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Location - City or cemetery, crematory or other place)  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  20c. Location - City or cemetery, remaining to the place)  29. Name and Address of Facility  29. Name and Address of Facility  29. Name and Address of Facility  20c. Location - City or cemetery, remaining to the place)  29. Name and Address of Facility  20c. Location - City or cemetery, remaining to the place)  20c. Location - City or cemetery, remaining to the place)  20c. Location - City or cemetery, remaining to the place)  20c. Location - City or cemetery, remaining to the place)  20c. Location - City or cemetery, remaining to the place)  20c. Location - City or cemetery, remaining to the place)  20c. Location - City or cemetery, remaining to the place of Disposition (Name of cemetery, crematory or other place)  21. Sunature of Funeral Service Licensee  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  29. Name and Address of Facility  29. Name and Address of Facility  20c. Location - City or cemetery  20c. Location - City or cemetery  29. Name and Address of Facility  20c. Location - City or cemet									
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rds, P	quires that n signed b uld be deta	ρ	Part If. Other significent conditions co	ntributing to death	but not resulting in the	underlying cause gr	ven in Part I.		obacco use contribute to ti Yes 2 <b>⊡√No</b> 3 ☐ Prob	he cause of death?		
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o	ling After Tune		1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, Da	ury 28b. Time	of 28c. Inju	4 🗀 Nursing		dence 6  □Other ( <i>Specit</i> how in <del>j</del> ury occurred	у)		
Division	lal or Attendii s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Ir building, e	rjury - At home, farm, s rtc. (Specify)	treet, factory, office		28f. Location (: City or Tox	Street and Number or Rura wn, State)	al Route Number,		
(	To the Hospital or Al within 24 hours after of To the Funeral Directompletely filled in by	edical			of examination and/or is				cause(s) and manner as s date and place, and due to			
	To the within 2 To the complet	W	29b. Signature and title of confitting	and and		29c. Licen	se number		29d. Date signed (Month, Jan 29 2004	<del>r</del>		
R	-(2)		30. Name and address of person who c Richard Palmer MD		death (flom 23a) (Type Them Avenu		te 310	Washing	h_ Dc 2003	2_		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 4 FEB 0 2 2004	32. Regis	trar's Signature	E		U				

State of Maryland / Department of Health and Mental Hygiene 2004 05232 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Physician January 30, 2004 1:07 a Butler Buchanan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Takoma Park Washington Adventist Hospital Montgomery 8. Date of Birth (Month, Day, Year)
Dec. 11, 19 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** Hours Min. 1 □ M 2 1 F 88 1915 Pennsylvania Yrs 207-16-0871 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28e-1 show r than "natural", or Items 23a or 28e-f shov tre Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland | Prince George's Landover Hills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6110 Parkwood Road 20785 U.S.A. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 <sup>Specili</sup>rican American 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Hair Dresser Self Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fil thent of Health and Mental H tent: If item 27 is marked ott jury or other traumatic even Jordan Alberta Butler ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Olive Anne Majors - Daughter 6110 Parkwood Road, Landover Hills, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. Mt. Olivet Cemetery 02/05/2004 Washington, DC 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signatur 1 Fun-ral Service Licensee 4739 Baltimore Ave., Hyattsville, MD Approximate Interval Between Onset and Death Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. PETERIOS CENORE CANDOVASCULAR DISERSE Immediate/Cause (Final disease or condition resulting in death) years Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Journal of this initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit and Due to (or as a consequence of): physicien Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy Month Dav Year for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown ted 24b. Were autopsy findings available prior to completion of cause of death? Comple page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) tuneral director Be examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 KNo 2 ER/Dutpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After **Natural** Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral t 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0185 ed cause of death (Item\_23a) (Type, Print) 30. Name and address of person who Duensbury Ray Hyattsuille MD 20787 State Registra

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05234 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Edgar Lee Bell, Jr. January 31 2004 7:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Yrs. Director 578-82<del>-</del>7144 May 2, 1958 Wash., DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's 1 TYes 2 No Clinton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9211 Stuart Lane 20735 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: δ Black 3 Widowed 4 Divorced Completed other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cook Private 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Edgar Lee Bell, Sr. 2 Mattie L. Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i Mattie L. Harrison - Mother 11407 Gunpowder Dr., Ft. Wash., MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 2/5/2004 Suitland, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 191V 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** SEPTCEMIA

Due to (or as a consequence of): /Medical Examiner AUTOTHMUNE DEFECTERLY SYNDROME if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nding physicien a O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident within 24 hours after deat To the Funeral Director; 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D50862 Shoul from JANUARY, 31, 2004 IMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sherif Hassan, M.D. 9831 Greenbelt Rd., #103, Lanham, MD 20706 31. Date filed (Month, Day, Year) FEB 0 5 2004 State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05235 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day February 4, Physician 2004 8:29a M Louise Brown Betty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 71 1 M 2 TE 469-34-5137 Minnesota Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f ehow The Medical Examiner must be notified at 1 ☐ Yes 2 No Arlington Arlington Director VΑ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 22201 3175 N. 17th St. by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
sant: if items 27 is marked other than "natural", or Items 23, ury or other traumatic event, the Medical Exercitinal must up or other traumatic event, the Medical Exercitinal must 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Marned 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Ø Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Symphony Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Woman's Committee 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mattie Nielsen Maurice Leach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1511 Live Oak Dr. Silver Spring, MD 20910 Shelley Brundage/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ■Burial 2 SCremation 3 Removal from State permit. Page Department of Important: If eny injury or 2/7/04 \* 4 Donation \* Other (Specify) Cremation Center Chantilly, VA Service Donosee 21. Signature of Murbhy funerally Home 4510 Wilson Blvd. Arlington, VA 23a. Pert1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Pancreatic Cancer /Medical Due to (or as a consequence of): **Examiner** Pneumonia Samentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cardio ulmonary Arrest and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2ᡌ No 24a. Was an autopsy performed certificate 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0056063 m.D.

Registrar

State

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

1500 Forest Glen Rd. Silver Spring, MD

20910

30. Name and address of per o who completed cause of death (Item 23a) (Type, Print)

Kanwaljit Nagi, MD

		1. Decedent's Name (First, Midd	le, Last)			artment of I		2. Date of Deat		3. Time of Death
Physici: Medic/		LANCE		BROWN					Y 2, 200	
Examin	er	4a. Facility Name (If not institution PRINCE GEORGES	-			4b. City, Town, of CHEVER	or Location of Deatl LY	n	4c. County of PRINCE	Death E GEORGES
uneral		5. Social Security Number	6. Sex X□ M 2□ F	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)     Use The DC
Director	-	578-66-8431 Usual Residence of Decedent		J4_				Bept, Z	7 1949	Wash., DC
show	٠.	10a. State 10b. County	1	10c. City, T	own or Lo	cation				10d. Inside City Limi 1 X Yes 2 ☐ N
items 23a or 28a-f show retinual be notified at	Director	D.C.				10f. Zip Code	Vashingto		0g. Citizen of Wh	
le or	Ö	10e. Street and Number	N D			101. 21p Code	20019		•	
ms 23	Funeral	5211 Cloud P1 11. Marital Status	12. Was De	cedent Ever in U.S.	13.	Was Decedent of I	Hispanic Origin? (S	pecify Yes or No-	14. Race	d States - American Indian,
ö	by Fur	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☑ Divorce	If Yes. G	2 No Bive	1	r Yes, specify Cub 1 ☐ Yes 2 🔀 No	Specify:	o nican, etc.)	Specify:	White, etc. Black
"natural", Idical Exz		15. Decede	nt's Education	1	6a. Deced	ient's Usual Occu	pation		16b. Kind of Busi	ness/industry
Median.	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	life.	DO NOT use retire	•	King		
ygien ver th	Con	12th				Labore		(C)		bor
oven	Be	17. Father's Name (First, Middle						ne (First, Middle, I		,
d Mer mark	2	George Br 19a. Informant's Name/Relation			19b. Mailir	ng Address (Street	土 <u>土</u> t and Number or Ru	len Bro		tate. Zip Code)
ith an 27 Is i		Deven Bailey								Md. 20785
Heal Item		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of natory or other pla	v Tew Tel			ity or Town, State
nt: If		13 Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (		n State			Cem. 2/12	/04	Onan	tico. VA
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturenty injury or other traumatic event, <u>tra Nudical Once.</u>		21. Signature of Funeral Service	Livensee	n Pell	0 22	. Name and Addr	ess of Facility	Capitol M	lortuary	, Inc.
100		23a. Part1. Enter the disease, o shock, or heart failure. Lis	complications that	caused the death.	Donnat ent	er the mode of dy	land Ave	or respiratory arm	vasn., Di est,	Approximate
nysician		shock, or heart failure. Lis Immediate Cause (Final disease or condition		each linb. oin Intoxicat	V					Interval Between Onset and Death
Medical		resulting in death)	Due to	o (or as a consequer	ice of):					
aminer	_	Sequentially list conditions,	b	o (or as a cons » uer	on offi					
ısıt	Examiner	Sequentially list conditions,  Tary leading to immediate cause. Enter Underlying Cause (Disease or injury)	<b>1</b> Due (1	o joi as a cons a uei	ice orj.					
and al-trar	xan	that initiated events resulting in death) Last	c. Due to							
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reath. ector: After this certificate has been signed by the attending p by the tuneral director, page 2 should be detached for use as i	ician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live	outcome of pregnancy birth 2 Tetal de gnant at time of deat	ath 3	Ectopic pregnand Other (specify)	у		23d. Date Monti	
ed by the detached	Physi	9 Unknown	9□ Unk	known						
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certificate rector, pag	0	25. Was case referred to medic	al				26. Place of De	ath (Check only on		2 ≥ No
is cer direct	O B	examiner? 1 XYes 2 No	Hospital:	]Inpatient 2☐EP	VOutpatier	nt 3K DOA C	hor	lome 5 Reside		(Specify)
leath. tor: After this certificate ha the tuneral director, page	n: T	27. Manner of Death  1 Natural 5 Pend	28a. Dat		3b. Time o	f 28c. Inju	iry at ork?	28d. Describe ho	w injury occurred	
death. stor: Al	catic	2 Accident inves	tigation 272/	2004 8	:15	<b>A</b> M 1	Yes 2X No	Unknown		
after d	Certification:	3 ☐ Suicide 6 🔏 Could 4 ☐ Homicide deter	mined 200. Fla	ce of Injury - At home Iding, etc. <i>(Specify)</i> a <b>1 Road</b>	e, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number n, State) <b>Easte</b> Washingt	or Rural Route Number on Ave. And She
within 24 hours after death  To the Funeral Director: completely filled in by the	Medical (	29a. Certifier 1 Certify (Check only one)	I Examiner: On the	he best of my knowle basis of examination anner stated.	edge, deat and/or in	h occurred at the t vestigation, in my	me, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and mani ate and place, an	ner as stated. Id due to the cause(s)
within 2 To the comple	Me	29b. Signature and title of certif				29c. Licen	se number	2	9d. Date signed	(Month, Day, Year)
· s + ō		> Quot	1-			0	CME		FEBRUARY	3, 2004
( )	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANA RUB (0, FU)  111 Penn Street, Baltimore, Maryland 2									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 05237 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CLARENCE **EDWARD** BROWN JANUARY 25, 2004 9:07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury 27686 Log Cabin Road Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 🕱 M 2 🗆 F Yrs. Director 215-36-0034 61 February 28,1942 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "neturel", or Items 23e or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 27686 Log Cabin Road 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No Army If Yes, Give Year or Dates: 1959–68 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after at Hygiene. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: white Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ss 1 and 2 should be fill of Health and Mental H litem 27 is marked oth Raymond Jay Brown Helen Pruitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judi Anne Brown/wife 27686 Log Cabin Rd., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dale 20c. Location - City or Town, Slate permit. Pages 1 Department of H Important: if ite any injury or ot once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Salisbury Crematory 1/28/04 <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Salisbury, MD 27. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association Tarid # 501 Snow Hill Rd., Salisbury, MD 21804 Compoor CFSP 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final **Physician** MINS disease or condition resulting in death) cucliac /Medical Due to (or as a consequence of) Examiner YES . Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed YRB that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed2 2 1 No 2 No 1 ☐ Yes or Attending Physician: After this certification funeral director, p 26. Place of Death (Check only ope) Be 25. Was case referred to medical examiner? Hospital: 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 110688 enuled M. amo m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUNALD EASTELN SHORE DRIVE, SALIS, 400 M WOOD MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State souls JAN 2 8 2004 Registrar

		•	For State Registrar	State of	Maryla	and / Depa	artmen rtificate	t of H	ealth a	and M	ental Hy	giene.	2001	+ 0523	38
	B1 1.1		Decedent's Name (First, Middle, Last	)							2. Date of Dea	ath Day	Year	3. Time of Dea	ıth
	Physicia /Medic		Patricia Ruth Do								Jan	23	2004	21:35 1	0 M
	Examin	er	4a. Facility Name (If not institution, give	. /		20.1/11	4b. City,		Location o				County of Dea		
		2	PONINSUID REGIONAL 5. Social Security Number 6. Se	Medi		rs. last birthday)	If Under		If Under		8. Date of Birt			rthplace (State or Fo	reian
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	anylar show	7	10a. State 10b. County		1	City, Town or Lo	ocation							10d. Inside City Li 1	_
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	3a or	i Di	P.O.Box 57					940				USA			
	death	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in	n U.S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	- 1	4. Race - Arr Black, Wh	encan Indian, ite, etc.	
9	or Its	y Fu	1 Never Married 2 Married	1 ☐ Yes If Yes, Give	2 ( <b>X</b> No 9		1 ☐ Yes		Specify:		,,		- "	hite	
21215-0036	hours tural	ed by	3 Widowed 4 Divorced  15, Decedent's Edu	Year or Da	ites:	16a. Dece	dent's Usua	d Occupa	ation			16b. Kir	nd of Busines		
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2	be filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. d other than "natural" or items 23a or 28a-f show event, "in Medical Exam narminal te notified at	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		Sumame)		
Maryland	should ind Men marka umartic	10	Richard H. Dodd  19a. Informant's Name/Relationship (T.	una Printl		10h Maili	na Address	(Stroot :			ght Dod		Town State	Zin Code)	
2	d 2 si Ith an 27 is r traur		Fred C. Burnette,		d						e. 1994		rown, blate,	Z.p oddo,	
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0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		SEP	TICEN	114						2 WEEK	<u> </u>
-6385	Examiner			Due to (i	or as a cons	sequence of):									
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137.	cien a		resulting in death) Last	Due to (	or as a cons	sequence of):									
43	• <u>w</u> > <u>w</u>	dical		d											
		Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out								2	3d. Date of de	elivery	
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a Be	e law has b	Completed by	MITTER LALVE,	REPLACE	MEN						24a. Was autor perfo		prior to death?	autopsy findings avai	able a of
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frie	W (0 =	To Be	examiner?	Hospital: 1	npatient 2	2 ☐ ER/Outpatie	nt 3□ DC	A Oth	or-		n <i>(Check only c</i> me 5 ☐ Resid		□Other (Sp	ecify)	
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Division	tendin death. for: Af the fur	ertification;	2 ☐ Accident investigation				М		Yes 2 □ I	-					
	or Att after d Direct in by t	rtific	3 Suicide 6 Could not be 4 Homicide determined	288. Place	of Injury - Ang, etc. (Sp.	At home, farm, st ecify)	reet, factory	, office		1	28f. Location (3 City or Tov	Street and vn, State)	d Number or F	Rural Route Number,	
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely illied in by the funeral	edical	(Check only 2 Medical Exam	iner: On the ba	asis of exam	nination and/or in	rvestigation	, in my o	pinion, dea	th occurr	ed at the time,	date and	place, and di	ue to the cause(s)	
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10D	00		30. Name and address of person who of POSOT FEED	completed caus	e of death (	Item 23a) (Type	, Print)	Ruc	STY	SAZ	rever	in	021	801	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 2 8	32. R	egistrar's Si		9 4								

State of Maryland / Department of Health and Mental Hygiene 10 Certificate of Death

1. Decedent's Name (First, Middle, Last)

05239

3. Time of Death

2. Date of Death

	Physicia /Medic			, ,	EMMA	S. CH	IFLEY	January 30,					, 200	ear 4	4:20	РМ	
)	Examin		4a. Fecility Name (II	f not institution, gir	e street and numb	oer)		4b. Cîty, T	own, or	Location o	of Death		40	c. County of	Death		
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ł	Funeral Director		5. Social Security No. 220-05-04	ast birthday) Yrs.	Months Days Hours Min. (Month, Day, Year) Country)					lace (State try) Land	or Foreign						
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Baltimore,	permit. Page Department of Important: If arty injury or page.		21. Sign. Fu	plsk Lie	(S) 91	A	ŘC 12	BERT Ul NO	Address E. I KTH	SATEE MARK	Y & ET S	SON FUN	VERA EDEK	L HOMI	ES,	P.A.	
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to	/Medical Examiner		resulting in death)	(	Due to (or	as a consequ	ience of):										
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o uoi	nding Ph ath. r: After th e funeral		27. Manner of Death  1 Natural  2 Accident	h 5 □ Pending investigatio		Injury Day Year)	28b. Time of Injury	M 28	c. injury Work 1   Y	at ? es 2 □ h		28d. Describe I	now inju	iry occurred			
Division of	the Hospital or Attending hin 24 hours after death. the Funeral Director: After inpletely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not to determined	280. Place of	f Injury - At ho , etc. (Specify	me, farm, stre	et, factory,	office			28f. Location (S City or Tox	Street ar	nd Number ( e)	or Rural	Route Nur	nber,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier (Check only one)	1 Certifying P 2 Medical Exa	hysician: To the b miner: On the bas and manne	is of examinat	wledge, death ion and/or inve	occurred at estigation, in	t the time	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s date an	and manne d place, and	er as sta	ated. the cause(	(s)
	To the within 2 To the complete	Me	29b. Signature and	title of certifier	1		1	29c.	License	number	7	MO	29d. Da	ite signed (A	Aonth, E	Day, Year)	

State Registrar 31. Date filed (Month, Pay, Year) FEB 0 4 2004

32. Registrar's Signature

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)
Eugene B. Casagrande, MD 1564 Opossumtown Pike, Frederick, Maryland

D40307

21701

State of Maryland / Department of Health and Mental Hygiene 2004 State Ragistrar Amended #6perFH FCHD, KS Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 1 2004 11:50 A Pearre Cramer Thomas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Northampton Manor Nursing Home Frederick Frederick 8. Date of Birth (Month, Day, Year) April 25, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours XXM 25 Yrs. 1914 Maryland 219-07-5988 89 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nant of Health and Mental Hygene.
and if Health and Mental Hygene.
and if Health and Zis marked other than "natural", or itams 23s or 28s-f show ury or other treumstic event, ha shocked Exprimite chall be notified at 1 ☐ Yes 2 X No Directo Walkersville Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21793 United States 9430 Woodsboro Pike Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Maryland 21215-0036 Specify: þ 3⊠Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Research Specialist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bessie Cramer Thomas Leslie Cramer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Walkersville, Maryland 21793 9430 Woodsboro Pike Beverly Shoemaker / Daughter Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 3 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Frederick, Maryland \* 4 □ Donation 5 □ Other (Specify) Frederick Crematory 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature V Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition (eno stace Physician ALZHERMERS DISEBSE Years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. detached the 9 Unknown 9 Unknown Š signed t 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed/ page 2 No 2 XN0 1 TYes certificate 1 Yes of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No မ 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Division Injury 1. Natural 5 Pending 1 Yes 2 No nin 24 hours after death. the Funeral Director: A investigation 2 Accident in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 32171 2/04 COM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALKERSUILLE an PO B000 328 RICHARD L. GOUGH 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05241 For Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 4,2004 3:55p M Henry Lewis Carter. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days Year) 1 MM 2 □ F 79 APRIL 1924 219-12-4376 VA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 XYes 2 □ No FREDERICK MIDDLETOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 S. JEFFERSON ST. USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Mayes 2 □ No 1944 -If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 1946 Specify: WHITE 3 M Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) FARMER AGRICULTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES BENJAMIN CARTER MARY ALICE LOONEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9608 PASTORA PL., COLUMBIA, MD 21045
e of Disposition (Name of Date 20c. Location - City or Town, State JAMES CARTER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State RESTHAVEN CEMET. 2/7/04 FREDERICK, MD '4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility HILTON FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 Leeks +n//nenza disease or condition resulting in death) Due to (or as a consequence of): 101 SPYTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Mellitan inhetts 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 371 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FLEMING, MD 610 9th AVE., BRUNSWICK, MD 21716 J. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ms 23a or 28e-f show must be notified at

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death

Baltimore, Maryland 21215-0036

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permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once.

**Physician** 

/Medical

Examiner

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After

To the Funeral

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To the Hospitel or Attending Physician:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

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State Registrar

FEB 0 5 2004



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dical	ŀ				4b City Tow	m, or Location of De		3,2004	unty of Death	15:0
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	٩	Southern Marylan  5. Social Security Number 6. Sex		n yrs. last birtho	(ay) If Under 1 Ye	ear If Under 24 H	rs. 8. Date of E	Rinth	9. Birth	place (State or For
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Director	2	Maryland Prince Ge	orge's			tville		T		
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Physician/Mer	ain.	23b. Was decedent pregnant in the past 12 months?	sc. If yes, outcome of 1☐Live birth 2 {	∃Fetal déath	3 □Ectopic pregn			23d	. Date of delin	very Day Year
اذا	210	1 Yes 2 No	4□Pregnant at tirr 9□Unknown	e of death	5 Other (specify	y)		-		/
		Part II. Other significant conditions confi	tributing to death but a	not resulting in the	ne underlying cause	e given in Part I	23a. Dio	d tobacco use	contribute to	the cause of death
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Cortification.	TICE	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm	, street, factory, of	fice	28f. Location	(Street end N	lumber or Rui	ral Route Number,
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	200	(Check only 2 Medical Examinone)	er: On the basis of example manner state		or investigation, in i	my opinion, death or	curred at the time	e, date and pla	ace, and due	to the cause(s)
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nael Campbell	State of Maryland / Department of Health and Mental Hygiene

4-00/31	Please	Type of Print in Black Indelible ink. Ensure A	ill Copies Are Legible.	
Michael Cam	obell 1- State Registrar	State of Maryland / Department of Health and N  Certificate of Death	Wental Hygiene 2 0 0 4	0524
	1. Decedent's Name (First, Middle, Las	st)	Z. Date of Death	3. Time of Death
Physician	Michael	Campbell	January 26 2004	1057 a

/Medical Examiner

**Funeral** 

Director ms 23a or 28e-f shor death r than "natural", or Item the Medical Examiner Il Hygiene.

filed within 72 hours after Pages 1 and 2 should be 1 nent of Health and Mental I ent: If item 27 is marked of item 27 is marke other traumatic Importent: If iten any injury or othe permit. Pag Department

Baltimore, Maryland 21215-0036

Box 68760,

Records, P.O.

Division of Vital

**Physician** /Medical Examiner

sician and burial-transit The law requires that the death certificate be executed as the use ō ed by the a detached for been signe should be page 2 s or Attending Physician: director, this After death. after death filled in by 24 hours a

within 2 To the I State

| January 26 2004 Campbell | 105/ a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace | Country | 16 | 16 | 1982 | Maryland 2709 Giles Road 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 15 M 2□ F 21 Yrs 218-02-5516 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Md. Directo Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1355 Spellman Road 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 ☐ Married 1 Yes 2 No Black Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Donna Campbell Marvin Johnson ٥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Campbell Mother 1355 Spellman Rd. Baltimore, Md. 21225 205. Pla of position (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ♣ Burial 2 Cremation 3 Removal from State King Memorial Park1/31/2004 Woodlawn, Md. <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Tri-State F/S/Inc. 21. Signature of Funeral Service Licenses 912 Third St.NW., wash.D.C.20001 2da. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Due to (or as a consequence of): Multiple resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ es 2 □ No 24a. Was an autopsy performed? 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatrent Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \cancel{\square}$  Other (Specify) at SCEDE 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 10:54AM 26.04 1 ☐ Yes 2 No subject shot 2 Accident investigation Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Jown, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide IN COS ATTOMOTIVE AND ARTICLE 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29d. Date signed (Month, Day, Year) January 27 2004

Registrar

29b. Sign sture and title of certifie

A 31. Date filed (Month, Day, Year)

FEB 05

LATRIC

30 Name and address of person who completed

2004

ause of death (Item 23a) (Type, Print)

29c. License number OCME

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 05241

					Cei	rtificate of	f Death		Reg. No. 4 U	U 4	05244
			1. Decedent's Name (First, Middle, Las	1)				2. Date of Dea	ath		3. Time of Death
Ŋ	Physicia		Joseph Contarino	Ir				Februa	Day Cy 2, 20	Year 104	9:00 a.m.
	/Medic		4a Facility Name (If not institution, give				4b. City, Town, or	Location of Death			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
3	Examin	er	6207 Ouebec Place				Berwyn	Unichta			
H			5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Yea			h 1 1 111C		orge's
	Funeral Director			71 M 2□ F	1 Yrs.	Months Days	s Hours Mir	8. Date of Birt (Month, Da	y, Year)		ace (State or Foreign
	Director	1	Usual Residence of Decedent	0	1	l		July 26	, 1922	wasni	Ington, DC
	and land		10a. State 10b. County	10c	. City, Town or La	cation				10	Dd. Inside City Limits
	Aarylar f show	5	), 1 1 D			TT 1 1 .					1⊠Yes 2□No
	the Marylar r 28a-f show	8	Maryland Prince  10e. Street and Number	George's	Berwyn	Heights			10g. Citizen of V	What Court	10.2
	£ 0 8	늄							•		ly r
	72 hours after death with the Maryland natural', or items 23a or 28a-f show ites! Examinet must be notified at	Funeral Director	6207 Quebec Place	40 W - B - 1 - 1 E - 1	-110	2074			U.S.A.		
	ter des	Š	11. Marital Status	12. Was Decedent Ever in Armed Forces?	0/0	f Yes, specify Cul	Hispanic Origin? ( ban, Mexican, Pue	to Rican, etc.)	Blac	e - America k, White, e	
20	s aft	by F	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 X Yes 2 □ No 1 If Yes, Give		1□Yes 21√2No	Specify:		Specify		
21215-0020	"natural",	무			1946			Т		Whi	
5	30	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Deced	kind of work done	upation e during most of wo ed)	orking	16b. Kind of Bu	siness/Indi	ustry
12	within ene.		Elementary/Secondary (0-12)	College (1-4or 5+)		al Tech.	60)		Donant		of Asserts
2	lled v lygie her t		12 17. Father's Name (First, Middle, Last)		Denta	ar recn.	10 Mathada Na	man /Firesh Adirectles			of Army
Ĭ	be f d of	B	17. Patrier's Name (First, Middle, Last)				10. MOLHET S 148	me (First, Middle,	Maiden Surnam	θ)	
ž	ould Merke	၉	Joseph Contarino					Barker			
Maryland	2 sh and is m	ŀ	19a. Informant's Name/Relationship (T)				et and Number or F				
	and n 27 ner tu		Joseph Contarino				Street, I	Brooklyn,	New Yo	rk 11	209
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Modes.		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ F	20 Computal from State	b. Place of Dispo	sition (Name of natory or other pla	ace)	Date	20c. Location -	City or Tov	vn, State
Ě	Pag Int: i		4 □ Donation 5 □ Other (Specify)		letropoli	tan Crem	atory	2/4/04	Alexand	ria,	Virginia
att	permit. Pa Departmen Important: any Injury		21. Signature of Funeral Service bicens	ee	, 22	. Name and Addr	ress of Facility Ga	asch's Fu	neral H	ome,	P.A.
m	Depa impo any i		1 Leasta	1211	10/4	739 Balt	imore Ave	., Hyatt	sville,	MD 2	0781
	SECTION A	$\dashv$	23a. Part1. Enter the disease, or complete	ications that caused the	leath. Do not enti	er the mode of dv	ring such as cardia	c or respiratory ar	rest	1	Approximate
	Disconinting		shock, or heart failure. List only o	ne cause on each line.		o. 1110 111000 0. 0,	ing, coor as sarais	or roopiratory at			Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final	/2	Λ.	0	1	1			
0.0	Examiner		disease or condition resulting in death)	a. Chrock	10/2 K	Kelore	ey M	2362		j	
П		-	J	Due t	o (or as a conseq	uence of):	W			l	
	ted sit	틭		o Cerse	leone	Jepan	ley				
	certificate be executed ding physician and ise as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a constaq	uence of):	1			4	
9	be e ician buria	8	cause. Enter Underlying Cause (Disease or injury	o							
68760,	cate phys	edical	that initiated events resulting in death) Last	Due to	o (or as a consequ	uence of):				1	
×	entifi ding se as	Š		4.						į	
Bo								- 11.			
	law requires that the death of a second as been signed by the attentor. I should be datached for un	Physician	Part II. Other significant conditiona cor	tributing to death but not	resulting in the ur	nderlying cause g	iven in Part I.	23b. Did to	obecco use con	tribute to	the cause of death?
P.0	d by atac	준						101	'es 2□ No	3 🗆 Proba	ably 4∑ Unknown
	es the	<u>ا ج</u>									
Š	en s ould	Completed						24a. Was a		24b. Wer avai	e autopsy findings lable prior to
ပ္ထ	aw re 1s be 2 sh	be								com of de	pletion of cause eath?
ď	The law ate has page 2	E						TUY	es 2XNJ	- 10	Yes 2□ No
ta	ician: The certificate rector, pag		25. Was case referred to medical				26 Place of De	ath (Check only or			
of Vital Records,	Physician: this certificanal director,	2	examiner? 1 ☐ Yes 2 ☒ No	lospital:	2 ☐ ER/Outpatien	t 3 DOA Ot	thor:	dome 5∑ Resid		r (Specify	
	Phys r this aral d		27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inju		28d. Describe h			
9	Attending or death.	ᅙ	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	r) Injury		ork? ∐Yes 2∐No				
İSİ	or Attend after death Director: /	<u>2</u>	3 Suicide 6 Could not be	28e. Place of Injury - A	At home, farm, stre	et, factory, office		28f. Location (S	treet and Numbe	er or Rural	Route Number,
Division	after Dire	티	4 ☐ Homicide determined	building, efc. (Sp				City or Tow	n, State)		
	Hospital 24 hours Funeral etely fillac	edical Certification:	29a. Certifier 1□ Certifying Phys	lcian: To the best of my	knowledge death	occurred at the t	imo, data and place	and due to the o	ouso(s) and may		tod
	Hos 24 hu Fun etely	음	(Check only 2 Medical Examinations)	ner: On the basis of exam and manner stated.	ination and/or inv	estigation, in my	opinion, death occi	irred at the time, d	ate and place, a	nd due to t	he cause(s)
		-	29b. Signature and title of certifier	i a		29c. Licen	se number	5	9d. Date signed	(Month D	av. Year)
	F 3 F 9			w				_	_	•	
	(11)		7	7			DO097	639	02-0	4-2	004
	10/40		30. Name and address of person who co		, , , ,	,					
			Fayaz Shaw1, MD	7620 Carro	ll Ayenu	e, Takom	a Park, N	Maryland	20912		
	Stat	е	31. Date filed (Month Bly4Year)	32. Restrar's							
4.5	<ul> <li>Registra</li> </ul>										

DHMH 16 Rev 6/95

		Stete Registrar  1. Decedent's Name (First, Middle, Las	*)	Cei	rtificate	e of L	eatn		2. Date of Dea	th	200	4 0524 3. Time of Death
hysici:	an		ARTER						Month Francos	Day	Year 2	2
/Medic xamin	-46	4a. Fecility Name (If not institution, give			4b. City,	Town, or	Location o	f Death	100,00	1100	County of Dea	
Xuiiiii		DOCTOR'S HOSPIT	AL			LANHA				PR	INCE G	EORGE'S
neral ector		5. Social Security Number 6. Se 254-11-9190	7. Age (Ir	yrs. last birthday) 43 Yrs.	If Under Months		Hours 1	Min.	8. Date of Birt (Month, Dat 08/12/	y, Year)	C	thplace (State or Forei ountry) EORGIA
14 404	5	Usual Residence of Decedent										10d. Inside City Limit
Important: If item 27 is marked other than "natural", or items 23s or 28e-1 show any injury or other traumatic event. The Medical Examittur runst be notified at <u>once.</u>	_	10a. State 10b. County		c. City, Town or Lo								1 Yes 2 N
286-1	Director	MD PRINCE G	EORGE'S	LANDOVE	SR 10f. Žip	Code				10g, Citiz	en of What C	ountry?
Sa or		812 FINCH DRIVE				207	'85			,	U.S.A	•
H8 2	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Deced			gin? (Spe	ecify Yes or No- Rican, etc.)	. 1		erican Indian,
or ite		1 Never Married 2 Married	1 ☐ Yes 2 🛣 No		1 Yes		Specify:	, 1 00110	rticari, etc./		Specify:	BLACK
LEXE	d by	3 Widowed 4 Divorced	Year or Dates:									- And rate (
adjes Teles	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usua kind of wor DO NOT us	rk done d	uring most	t of worki	ing	100. KII	d of Business	windustry
E M	E O	Elementary/Secondary (0-12) 10TH	College (1-4or 5+)	9	SUPERV	ISOR	}			P	RIVATE	
othe ent.	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	First, Middle,	Maiden :	Sumame)	
tic e	To B	WINKFIELD PARK	S SR.				INI	EZ C	LARK			
is me		19a. Informant's Name/Relationship (7			•				AI Route Numbe			Zip Code)
m 27 her tr		SAMUEL CARTER SR		OIZ I	FINCH		E LA		VER, MD			Town, State
or of		20a. Method of Disposition  1 Disposition  2 Cremation 3 Disposition	Removal from State	cemetery, cre	matory or o	ther place	1					
rtant: njury		* 4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen	-	LINCOLN	CEMET 2. Name an				07/04 B. JENE			ARYLAND T HOME
Importa eny inju once.		21. Signature of Pulleral Service Licen	a 1/1		474 L				LANDO			
9		23a. Part 1. Enter the disease, or comp	olications that caused the									Approximate Interval Between
sician		shock, or heart failure. List only Immediate Cause (Final		IRATORY	FATLU	RE.						Onset and Death
dical		disease or condition resulting in death)	Due to (or as a co									
miner		Sequentially list conditions	b	INOMATOS	IS							
sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co		OMA O	ייני קו	NTC!					
and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a co	O CARCIN	OMA U	r LU	NG					
nysician and he burial-transit	cal E		d									
g phy: as the	ed		· · · · · · · · · · · · · · · · · · ·									
attending phy I for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		□Ectopic pr	regnancy				2	3d. Date of de	
he att	sicio	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at tim 9□ Unknown		Other (sp						Month	Day Year
ed by the a	Phy	9 Unknown  Part II, Other significant conditions of	potributing to death but o	of reculting in the I	inderhina c	alice dive	n in Part I		23e. Did to	nbacco us	se contribute :	to the cause of death?
signe 1 be d	by	raitii. Other significant conditions c	official and the desired at the	or resulting in the c	andonying o	auso give	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,				robably 4 Unknow
should be	Completed								24a. Was			utopsy findings availat
has je 2	E D								autor	rmed?	prior to death?	completion of cause of
certificate rector, pag		25. Was case referred to medical					26. Place	of Deat	1 ☐ Yes		1 🗆 Yə	s 2□No
	To Be	examiner? 1 ☐ Yes 2 🕏 No	Hospital: 1 🛣 Inpatient	2 ER/Outpatie	nt 3 DC	OA Othe			me 5 Resid		Other (Sp.	ecify)
9		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time o	of 2	28c. Injury Work	at c?		28d. Describe !	now injury	occurred	
tor; Aft the fun	ertification:	2 Accident investigation			М	1 🗆 `	Yes 2	No				
Director: In by the	E	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	<ul> <li>At home, farm, st Specify)</li> </ul>	treet, factory	y, office			28f. Location (3 City or Tox			Rural Route Number,
	O	29a. Certifier 1序 Certifying Ph	ysician: To the best of n	ny knowledge, dea	th occurred	at the tim	ne date an	nd place	and due to the	cause(s)	and manner a	e stated
illed	edical		niner: On the basis of ex	amination and/or in								
unerel ly filled		29b. Signature and title of certifier			290	c. License	number			29d. Date	signed (Mor	oth, Day, Year)
unerel ly filled	Me	200. Olgitatoro and the or sorting										0001
To the Funeral Direct completely filled in by	Me	<b>)</b>	1	1	-	D 31	069		1	ERKL	IARY 4,	2004
unerel ly filled	Me	30. Name and address of person who	completed cause of deat						4D 20774		IARY 4,	2004

Anthony T. Carozza 1 - For State Registrar

Physician

1. Decedent's Name (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death

2. Date of Death

Month

Dav

Year

USA

Specify:

LAW

14. Race - American Indian, Black, White, etc.

WHITE

05246

а

451

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

BALTIMORE, MD

ANTHONY THOMAS CAROZZA January 27 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Fruitland Little League Park Fruitland Wicomico If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1√2 M 2□ F Months Hours Director 40 11-15-1963 220-76-2133 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County Items 23a or 28a-f ehow Examiner must be notified at Director WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4456 STURBRIDGE DRIVE 21804 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) pernit. Pages 1 and 2 should be tiled within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or ite eny injury or other treumatic event, the Medical Examina 1 ☐ Never Married Ž ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ASST. PUBLIC DEFENDER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANTHONY F. CAROZZA MARY PAT ROHE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAIL CAROZZA - SPOUSE 4456 STURBRIDGE DRIVE, SALISBURY, MARYLAND 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) EVERGREEN CEMETERY 01-31-2004 BERLIN, MARYLAND 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Suneral Se 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 Dart1. Enter the disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 61 **Physician** 

/Medical Examiner

burial-transit

Examiner Physician/Medical δ Completed Be Medical Certification; To ospital ...
4 hours after dea...
-ral Director: After

25. Was case referred to medical

5 Pending

investigation 6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

Suicide

Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed

certificate

After

within 24 hours of

funeral director

P.O. Box 68760

Division of Vital Records,

sh	ock, or heart failure	cations that caused the death. Do no	t enter the mode of dying, such as cardiac or		Approximate Interval Between Onset and Death
disease	ite Cause (Final or condition in death)	Due to (or as a consequence of)	ing Wands of Wrists	complicated by Hay	pollermia
if any, le cause. Cause (i that initial	ially list conditions, ading to immediate Enter Underkying Disease or injury ated events in death) Last	Due to (or as a consequence of)  Due to (or as a consequence of)			
in t	LE: s decedent pregnant he past 12 months? Yes 2 \( \sum \) No Unknown	3c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3□Ectopic pregnancy 5□ Other (specify)	23d. Date of d Month	lelivery Day Year
Part II. O	ther significant conditions cor	ntributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?

Hospital: 1 Inpatient

28e. Plac

28a. Date of Injury (Month, Day Year)

23e. Did tobac	co use cor	tribute to the cau	ise of death
1 ☐ Yes	No	3 Probably	4 Unkno
24- 146	0.45	Mara auto-auto-	diago avado

January 28 2004

Yes 2 🗆 No

24b.	Were au	topsy findir	ngs available of cause of
	death?		
	A 100		

26. Place of Death (Check only one)

2	ER/Outpatient	3 🗆 🛭	DOA Other:	4 🗌 Nursing H	lome	5 Residence	6  € Other (Specify)	at	scene
ar)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes		28d.	Describe how injusting	ury occurred	13	and fil

e of Injury - At home, farm, street, factory, office ling, etc. (Specify)	City or Town, State)	MD	2152
e best of my knowledge, death occurred at the time, date and pla- basis of examination and/or investigation, in my opinion, death oc-			

OCME

9a. Certifier	1 Certifying Phy	sician: To the best of my knowled	dge, death occurred at the time, date and place, and due to	the cause(s) and manner as stated.
(Check only		iner: On the basis of examination	and/or investigation, in my opinion, death occurred at the	
		and manner stated.		
oh Signatura ar	nd little of continer	_	29c. License number	29d Date signed (Month Day Year)

eath (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 10 4 05247 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $7^{\text{Day}} 30, 2^{\text{Year}} 4$ **Physician** January WILLARD WALTER DAVIS 3:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL FREDERICK menofuci 40 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 14 Birthplace (State or Foreign Country) **Funeral** Min 216-22-7535 1 M 2 F Days Hours FREDERIK MA Director Usual Residence of Decedent the Maryland 10c. City, Town or Location, 10a State 10h County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No FRENERICK MERICK Director 10e. Street and Number 10g. Citizen of What Country? Cl. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "naturat", or items 23s eny injury or other traumatic event, tra Medical Esaminar must once. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 Yes 2 No ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) TECH 17. Father's Name (First, Middle, Last) . 18. Mother's Name (First, Middle, Maiden Sumame, WILLIAM DAVIS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ST. ANT 10 1499 GAST 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State FRED. `4 □Donation 5 □ Other (Specify) STHAVEN ( 21. Signature of Funeral Service Licensee 22. Name and Address of Facility L. ROLLINS FUNGAL 1720 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) avasomy Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause that Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Hakanwa 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA this ate f Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident s after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Funeral Director etely filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the e 29c. License number 29b. Signature and title of certifier 2 D0000 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnson 31. Date filed (Month, 32. Regisar's Signature State Registrar

Physic										
/Medi Exami		4a. Facility Name (If not institution, give		4b. City, Town, Mt . A	or Location of Do		4c. County of Deett			
Funeral Director		5. Social Security Number 6. Social Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		yrs. last birthday 53 Yrs.	Months Days		Irs. 8. Date of Birth (Month, Day, April 7	Year) 9. Birth Co.	plece (State or Foreign Intry) Cyland	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28s-f show any nurry or other traumatic event, the Medical Examinar must be notilised at once.	ctor	10a. State 10b. County Maryland Freder	ick	c.City,Town orL	ocation				10d. Inside City Limits 1 ☐ Yes 2 1 No	
	i Director	10e. Street and Number 7641 Dollyhyde Ro	ad		10f. Zip Code	771	1	Og. Citizen of What Cou	untry?	
	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S. 13.		Hispanic Origin? pan, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Amer Black, White Specify:		
	Completed by	15. Decedent's Ed (Specify only highest gra		(Give	edent's Usual Occu e kind of work done DO NOT use retire	during most of t	working	16b. Kind of Business/Industry		
	To Be Co	12 17. Father's Name (First, Middle, Last) Chester Delaute	Name (First, Middle, I	Food and Drug Admin. st, Middle, Maiden Sumame) ickenstaff						
	-	19a. Informant's Name/Relationship (7					Rural Route Number	City or Town, State, Zip Code)  Maryland 21771		
		20a. Method of Disposition  1 ♣ Burial 2 ☐ Cremation 3 ☐  1 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		osition (Name of matory or other place ove Ceme			20c.Location - City or T Mt. Airy, M		
Deport Deport Import any nj		21. Signature of Funeral Service Licen	Stevens		2. Name and Address 21 Oposs			Funeral Homerick, Mary		
Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	· Cano	lias	ter the mode of dy	ng, such as card	liac or respiratory arre	est,	Approximate Interval Between Onset and Death	
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to fras a co	nsequence of):	gra	olos	4		2 hords 5 year	
iing Physician: The law requires that the death certific. It faiter this certificate has been signed by the attending phoneral director, page 2 should be detached for use as to the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1  \( \text{Yes} \) > 2 \( \text{T} \) No	d	Fetal death 3	□Ectopic pregnanc	у		23d. Date of deliv	ery Day Year	
	by Phys	9 Unknown  Part II. Other significant conditions of	9⊡ Unknown	ot resulting in the u	ınd <b>erlyi</b> ng cause gı	ven in Part I.	23e. Did tob	acco use contribute to t	the cause of death?	
	Completed		24a. Was ar	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown  24a. Was an autopsy findings available prior to completion of cause of						
	O	25. Was case referred to medical				26. Place of D	perform	death? No 1 ☐ Yes		
	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie		ner: 4 Nursing	Home 5 Reside	nce 6 □Other (Specia	(y)	
	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1	ry at rk? Yes 2 □ No				
i Zi te o		4 Homicide determined	City or Town	Location (Street and Number or Rural Route Number, City or Town, State)						
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Check only 2   Medical Examone)	use(s) and manner as s ite and place, and due t	stated. o the cause(s)						
To th To th comp	×	29b. Signature and title of contition			DOD 3	3532	od. Date signed (Month, $3 - 5 - 04$	te signed (Month, Dey, Year)		

State of Maryland / Department of Health and Mental Hygiene 2604 05249 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1816 **Physician** 200 January Z Anth Dean 4a. Fecility Name (If not institution, give street and number) /Medical 4c, County of Deeth 4b. City, Town, or Location of Death Examiner 1100h 5. Social Security Number Hager Ma STOWN 050 130 If Under 1Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days **Funeral** Months 1⊠M 2□F 39 Yrs 1964 Washington, 579-96-0806 Director Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County and Mental Hygiene. and Mental Hygiene. is marked other than "natural" or Itams 23a or 28a-f show raumatic event, the Madical Examiner must be notified at NOYes 2 □ No Hagerstown Maryland \_Washington Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21740 <u>240 Prospect Avenue</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1□Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Human Development Center Laborer 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be 2 Barbara Jean Simmons Thomas edward Dean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20774 permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau Eric Donell Taylor/Half brother 11317 Kettering Place Upper Malboro, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 7, 2004 Hagerstown, Maryland Rose Hill Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 Part1. Enter the trisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of): **Examiner** 25 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner law requires that the death certificate be executed 2035 and burial-tran to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending physic for use as the b IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No detached 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has page 2 2 2 No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No Hospital: 1 Inpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After Division or Attending 5 Pending investigation 1 Natural 1 □ Yes 2 □ No death. 2 Accident the Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by hin 24 hours after the Funeral Direct 4 Homicide 🌊 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Madicel Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 56824 281 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Z17/3 32. Megistrar's Signature State marked Registrar

			For State Registrar	State of Maryla	ınd / Dep		Health and	Mental Hygi		4 05251	
E:	nysicia Medic xamin neral	al	1. Decedent's Name (First, Middle, Last Anna Mae  4a. Facility Name (If not institution, give 5. Social Security Number 6. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Number 1.0. Security Num	Dorsey street and number) of Baltw	V6(L s. last birthday Yrs.	Boilton		ty	Day Yeer 2004 4c. County of Dec	3. Time of Death    O	
ith the Maryland		Director	Usuel Residence of Decedent  10a. State 10b. County  Md •  10e. Street and Number	Ва	City. Town or L				ng. Citizen of What C	10d. Inside City Limits 1	
72 hours after death w	other traumatic event, it a Mudical Examination and the colline in	d by Funeral	Md.  De. Street and Number  3505 Fairview Ave  1. Marital Status  X Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Education  (Specify only highest grade comple  Elementary/Secondary (0-12)  12 Years  7. Father's Name (First, Middle, Last)  James Dorsey  9a. Informant's Name/Relationship (Type, Print)  Phyllis Tyndell (Notation)  A Burial 2 Cremation 3 Removation  A Donation 5 Other (Specify)  11. Signature of Funeral Service Licensee  12. Was  Arma  1	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cut	Specify Yes or No- nto Rican, etc.)	erican Indian, ite, etc. .ack			
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permit. Pages 1 and 2 Department of Health i	any injury or ot once.		X□ Burial 2 □ Cremation 3 □ 8  '4 □ Donation 5 □ Other (Specify,	St	Luke	22. Name and Addr	ess of Facility $Tr$	1/2004 S	ykesvill F/S/Inc D.C.,200	e,Maryland	
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cian: The law	tor, page 2 st	se Completed	25. Was case relerred to medical examiner?				26. Place of De	24a. Was an autopsy perform  1 Yes 2	prior to death? No 1 □ Yes		
To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death.	by the funeral direct	Certification: To B	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence  27. Manner of Death 1 Natural 5 Pending investigation 2 Accident (Month, Day Year) September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 1 Yes 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No September 2 No Sept							injury occurred  at and Number or Rural Route Number,	
the Hospital or	pletely filled in	edical	29a. Certifier 1 Certifying Phy	rsician: To the best of my kiner: On the basis of examand manner stated.	nowledge, dea	nvestigation, in my	opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner a te and place, and du	e to the cause(s)	
U (	2 6	M	29b. Signature and title of certifier  Myun Cul  30. Name and address of person who co	ompleted cause of death (I	tem 23a) (Type	Res	se number	) ) ) .	d. Date signed (Mon	th, Day, Year)	
K (	Sta legistr		Ryan (W Ital)  31. Date filed (Month, Day, Year)  FFR 0 4 2004	32. Registrar's Sign	nature /	pital 3	or Balt	more	3		

State of Maryland / Department of Health and Mental Hygiene 2004 05251 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Ann Vesta Doleman 4:00 Feb. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Washington Beverly Health Care Center Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖾 F Yrs. 06/04/1931 72 MD 216-38-1122 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a State 10b. County Items 23a or 28a-f show Item rust be notified at 1 X Yes 2 ☐ No Director Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21740 USA 210 N. Jonathan Street Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items any injury or other traumatic event, the Medical Examera in any injury or other traumatic event. 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Ellen Bell Doleman Joseph Booker ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 72 Wayside Drive, Hagerstown, MD 21740 Anthony Doleman/Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 02/12/2004 | Hagerstown, MD Rose Hill Cemetery 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastalio Pancreatu Caremina 267 on 16 Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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1 □ Yes 2 □ No 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ate has been signipage 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 20 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manher of Death 28b. Time of Natural 5 Pendina 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 / Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MANZAA. D.SHAFI 3H Corl D28365 2-8-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manzar Shafi, M.D., 368 Mill Street, Hagerstown, MD 21740 32. Registrar's Signature 31. Date filed (Month, Day Year) 9 2004 State Registra

David D. Dennis Jr

	•	1 - For State Regis	trar			Cei	tificate	of De	eath		reg. No.	2004	0525	
Dhusi			nt's Name (First, Middle, La							2. Date of Dea Month	ath Day	Year	3. Time of Death	
Physici /Medi			id Dean Denn							Januar		2004	1846 p	
Examir	ner		Name (If not institution, gir insula Regio			tor		own, or Lo Sbury	cation of Death			ounty of Death		
					Age (In yrs. Ia		If Under 1	Year If	Under 24 Hrs.	8. Date of Birtl	h		place (State or Foreig	
Funeral Director	1	1		1 X M 2 □ F	25	Yrs.	Months	Days H	Hours Min.	9-29-7	y Year) 8	Cou	Md.	
D .			idence of Decedent		10. 0:-	Y							10d. Inside City Limit	
show	_	10a. State	10b. County			Town or Lo	cation						1 ☐ Yes 2X ☐ No	
ours after death with the Marylan el', or Items 23a or 28a-f show Examinet must be nutified at	Director	De	. Susse	X	De.	lmar_	10f, Zip C	ode			10a Citize	n of What Cou		
a or i	ō			L.O.				9940			US		, .	
ns 23	by Funeral	14 L L	O Oak Branch	12. Was Decede		3. 13.	1		anic Origin? (Sp	ecify Yes or No- Rican, etc.)		. Race - Ameri		
within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Musical Exeminer must be multified at	Fun		ever Married 2 Married	Armed Force						Rican, etc.)		Black, White,		
le di	by	3 □ W	idowed 4 Divorced	Year or Date	If Yes, Give Year or Dates:			1 ☐ Yes 2 🕅 No Specify:			Spe		pecify: White	
natu	Completed		15. Decedent's E (Specify only highest gi	rade completed) (Give			dent's Usual Occupation I kind of work done during most of working DO NOT use retired)			ing	16b. Kind	6b. Kind of Business/Industry		
han a	mpl		tary/Secondary (0-12)	College (1-4	or 5+)		ndor	retirea)			Vend	ing mad	rhinec	
permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examination once.		12	's Name (First, Middle, Las	(t)		vei	idor	18	I. Mother's Nam	e (First, Middle,			IIIIes	
ed of o	Be		d Dean Denni							lls Alexander				
mark mark	2		mant's Name/Relationship			19b. Mailir	ng Address (			al Route Numbe			Code)	
and 2.		June	Alexander,	mother		14110	Oak 1	Branc	h Rd. D	elmar,	De. 1	9940		
f Hearl		20a. Meth	od of Disposition		1 00	ace of Dispo	sition (Name	of		Date		tion - City or To	own, State	
nent of nent: If it ary or o			urial 2 Cremation 3 onation 5 Other (Spec		ate		Cemet		1-29	-04	Pitt	sville,	Md.	
permit. Page Department of Importent: If any injury of	1	21. Signa	twre of Funeral Service Lice	ensee		22	Name and	Address of	of Facility al Home	Inc		-10		
Depar Impor		1	toguat	1		1 1	3 E.	Grove	St. De	1mar. D	e. 19	940		
		23a. Part shoo	1. Enter the disease, or conck, or healt failure. List ont	nolications that cau y one cause on eac	sed the death	. Do not ent	er the mode	of dying, s	such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
hysician		Immediate Cause (Final disease or condition resulting in death)  a. Head and Neck mjuries								Orisot and Death				
/Medical Examiner		resulting	in death)	Due to (or	as a consequ	ence of):								
Ad III	<u></u>	Sequentia	ally list conditions,	Due to (or as a consecuence of):										
usit ea	Examiner	cause. E	ally list conditions, dury to immodule inter Underlying isease or injury											
cate be executed physician and the burial-transit	Exal	resulting in death) Last  Due to (or as a consequence of):												
/sicia e buri	dlcail													
Tilicar ng ph) as th	Medi	10.001111												
death certific e attending p d for use as	Physician/Me		decedent pregnant	23c. If yes, outco	me of pregnar h 2 □ Fetal		Ectopic pre	gnancy			230	d. Date of deliv Month	ery Day Year	
the at	Sici	1 🗆	e past 12 months? Yes 2 No Unknown	4□Pregnar 9□ Unknow	nt at time of de m	ath 5	Other (spe	orfy)				***************************************	,	
± > 3	Phy		her significant conditions	contributing to dea	th but not resu	Iting in the u	nderlying cau	ıse given i	in Part I.	23e. Did to	obacco usa	contribute to t	he cause of death?	
c 2 %	1 by			<b>3</b>			,			1 🗆 Y	/es 2 💥 i	No 3□Prol	bably 4 Unknow	
es lgn be	etec									24a. Was	an I	24h Were auto	opsy findings availab	
v requires been sign should be										autop perfor	rmed?	prior to co death?	mpletion of cause of	
e law requires has been signi je 2 should be	mp							20	6 Place of Deat	1 Yes	2 No	1 X Yes	2 No	
The law requires ate has been sign page 2 should be	Completed	25 Was	rase referred to medical		patient 2 🗆 F	ER/Outpatie	nt 3😡 DOA	Other		me 5 Resid		Other (Specia	fv)	
The law requires ate has been sign page 2 should be	Be	exam		Hospital:			- 23	c. Injury at Work?						
Physicien: The law requires this certificate has been signi ral director, page 2 should be	To Be	exami 1X Y 27. Mann	iner? les 2 No er of Death	28a. Date of	Injury	28b. Time o				oriver of a motor velicle which				
ding Physicien: The law requires h. After this certificate has been sign funeral director, page 2 should be	To Be	exami 1√2 Y 27. Mann 1 □N	iner? es 2 No er of Death atural 5 Pending accident investigati	28a. Date of (Month,	Injury Day Year)	Injury	PM	1 Yes	s 2 No	Stra	CK a	fixed	object	
lending Physicien: The law fequires leath.  tor: After this certificate has been sign the funeral director, page 2 should be	To Be	exami 1 2 Y 27. Manni 1 N 2 X A 3 S	iner? es 2 No er of Death atural 5 Pending	28a. Date of (Month,	Injury Day Year) O'4 I Injury - At ho	Injury 1728 me, farm, st	P M reet, factory,	1 Tes	s 2 No	28f. Location (S	Street and I	Vumber or Bur	al Boute Number	
or Attending Physicien: The law requires filer death.  Director: After this certificate has been sign in by the funeral director, page 2 should be	Certification: To Be	exami 1 2 Y 27. Manni 1 N 2 X A 3 S	iner?  es 2 No  er of Death atural 5 Pending iccident investigati cuicide 6 Could not	28a. Date of (Month,	Injury Day Year)	Injury 1728 me, farm, st	P M reet, factory,	1 Tes	s 2 No	Stru	Street and I	Vumber or Bur	onjeu	
or Attending Physicien: The law requires filer death. Director: After this certificate has been sign in by the funeral director, page 2 should be	Certification: To Be	9xami 1 2 Y 27. Manni 1	iner? es 2 No es 2 No es of Death atural 5 Pending investigati suicide 6 Could not determine  ifier 1 Certifying 1  zet only  2 Medical Ex	28a. Date of (Month, on 1-25 - 28e. Place of building)  Physician: To the baminer: On the bas	Injury Day Year)  Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Inj	Injury 1728 me, farm, st Road wledge, deat	reet, factory,	1 Yes	s 2 No	28f. Location (S City or Tow Delma and due to the	Street and I vn, State)	Vumber or Rum 454 00 DE and manner as s	al Route Number, a. K. Branch	
or Attending Physicien: The law requires filer death. Director: After this certificate has been sign in by the funeral director, page 2 should be	edical Certification: To Be	9xam 1 2 Y 27. Manna 1 N 2 X A 3 S 4 H	iner?  es 2 No er of Death atural 5 Pending investigati suicide 6 Could not determine  ifier 1 Certifying 1  ckt only 1  Medical Ex.	28a. Date of (Month)  be 28e. Place of building	Injury Day Year)  Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Inj	Injury 1728 me, farm, st Road wledge, deat	P M reet, factory, h occurred a vestigation, i	1 ☐ Yes office the time, n my opini	date and place, ion, death occur	28f. Location (S City or Tow Delma and due to the ored at the time, or	Street and five, State)  Cause(s) ardate and pl	Number or Rum 454 00 DE not manner as slace, and due to	al Route Number, ak Branch stated.	
or Attending Physicien: The law requires after death. Director: After this certificate has been sign in by the funeral director, page 2 should be	Certification: To Be	9xam 1 2 Y 27. Manna 1 N 2 X A 3 S 4 H	iner?  es 2 No  er of Death atural 5 Pending investigati determine  iffier 1 Certifying I  ck only 2 Medical Ex.  ature and title of certifier	28a. Date of (Month, on 1-25 - 28e. Place of building)  Physician: To the baminer: On the bas	Injury Day Year)  Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Injury - At ho Inj	Injury 1728 me, farm, st Road wledge, deat	reet, factory, h occurred a vestigation, i	1 Yes	date and place, ion, death occur	28f. Location (S City or Tow Delma and due to the ored at the time, or	Street and the street and the street and the street and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and	Vumber or Rum 454 00 DE and manner as s	al Route Number, al K B ranch stated. o the cause(s)  Day, Year)	

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) JAN 2 8 2004

Sparks

32. Registrar's Signature

		1	For State Registrar	State of Maryla	and / Depa	rtment of H	eaith and M	ental Hygi	ene 2004	-,
*	Physiciar	1000	. Decedent's Name (First, Middle, Las KENNETH	LAWRENCE	EVA	NS, SR.		2. Date of Death Month	Day Year	3. Time of Death
•	/Medica Examine	1	a. Facility Name (If not institution, give	street and number)		4b. City, Town, or LANHAM	Location of Death	JANUARY	4c. County of Deat PRINCE G	h
	Funeral Director		317 02 2207		rrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JAN • 30 ,	Year) 9. Birt Co	hplace (State or Foreign untry)  C.
	thow		Jsual Residence of Decedent  10a. State 10b. County  MD • PRINCE		City, Town or Lo	cation				10d. Inside City Limits 1X Yes 2 □ No
	r 28a-1	Director	Oe. Street and Number	GEORGES	LAUKEL	10f. Zip Code		10	g. Citizen of What Co	
	23a o	<u>a</u>	13601 BARNET LAN	E # 22		20708			U. S. A.	
986	urs after dea al', or Items	7	11, Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Privorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2X No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: BL	e, etc.
Kenneth EVans Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avant, its Medical Examinat must be notified at once.	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give	DO NOT use retired,	luring most of worki	ng	6b. Kind of Business/ Delivery	Industry
EVa land 2	and be filed we dental Hygie rked other!	To Be Co	10 17. Father's Name (First, Middle, Last) Purvis Lawrence		DI	iver	18. Mother's Name Mildred		•	
<i>₩</i> Mary	d 2 shouth and N		19a. Informant's Name/Relationship ( Mildred T. Evans	Type, Print) (Mother)		g Address <i>(Street a</i> 1 Barnet			city or Town, State, 20	
enneth	theal item 2 other	-	20a. Method of Disposition		b. Place of Dispo	sition (Name of natory or other place		ate 2	20c. Location - City or	Town, State
Z m	Page ment c ent: If ury or	1	1 XBurial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify	v)   M		t Cemeter		5-04	Washington	n, D.C.
Balt	permit Depart Import any in		21. Signature of Funeral Service Licer	Bacon CC:	361 34	47 14th S	on Funera St., NW V	Vashingt	on, D. C.	20010
	Physician		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Met	leath. Do not ent	er the mode of dying	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		1	Due to (or as a con	sequence of):		_			
760,		Exa	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con						
6876	ficate b	edical		_ d						-
Вох	The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the lines.	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \begin{array}{c} \text{Tyes} & 2 \( \begin{array}{c} \text{No} \\ 9 \end{array} \text{Unknown} \)	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dale of del Month	ivery Day Year
rds, P.O	quires that the signed by all be detacted.	5	Part II. Other significant conditions of	contributing to death but not	resulting in the u	nderlying cause give	en in Part I.		acco use contribute to s 2 □ No 3 12 Pr	the cause of death?
Division of Vital Records,	The law requirate has been si page 2 should	Completed						24a. Was ar autops perform 1 🗆 Yes 2	prior to death?	stopsy findings available completion of cause of
Vita	cien: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death			
on of	Phys r this rat dii	tlon: To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o Injury	28c. Injury Work	4 ∐ Nursing Ho		nce 6 □Other ( <i>Spe</i> w injury occurred	cify)
Divisi	Hospital or Attending 24 hours after death. Funerel Director: Afte tely filled in by the fune	Certification:	3 Suicide 6 Could not b 4 Homicide determined			eet, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	ıral Route Number,
_	Hospi 24 hour Funer	edical C		nysician: To the best of my niner: On the basis of exan and manner stated.						
•	To the within 2 To the comple	Me	29b. Signature and title discertifier	e and		29c. License			ed. Date signed (Mont	h, Day, Year)
CIP	(8)		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print) Ave 10	26287 07 C	ollege.	Park M	D 20740
	Stat Registra		31. Date filed (Month, Day, Year) FEB 0 2 2004	32. Registrar's S	ignature	e e				

			Fied State Registrar	State of N	Marylan	d / Depa	artme	nt of	Health and I	Mental H	ygien Reg. N	e2004	05254
	Physicia		1. Decedent's Name (First, Middle, I Michael Marcel	-	ı					2. Date of 0 Month		yay Year	3. Time of Death 4:55 A M
	/Medic Examin		4a. Facility Name (If not institution, g		r)				or Location of Deat			c. County of Deat	
	Funeral Director		none	Ospital Sex 7.7 1⊠M 2□F	Age (In yrs. 34	last birthday) Yrs.	If Und Months	er 1 Yea Day:		(Month, I	Birth Day, Yea	9. Birt Co Nige	hplace (State or Foreign ountry) eria
	e Maryland ia-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD			y, Town or Lo Baltimo							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Sa or 28	Dire	10e. Street and Number 1100 Sandy Stor	ne				ip Code 2122			"	Citizen of What Co Nigeria	ountry?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic evant, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☒ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force	s? ≹No	.S. 13.		edent of ecify Cu	Hispanic Origin? (S ban, Mexican, Puer	pecity Yes or I to Rican, etc.)		14. Race - Ame Black, White Specify: B1s	e, etc.
Maryland 21215-0036	vithin 72 hou ne. han "natura e Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-40	r 5+)		kind of w DO NOT	vork don use retii	upation e during most of wo red)	rking		Kind of Business/	
land 21	ould be filed within Mental Hygiene. Arked other than atic evant, the Manatic evant, the	To Be Co	17. Father's Name (First, Middle, La Egbujonuma Du	4yrs.	•	Cat	Dri	lver	18. Mother's Nan	me (First, Midd Egbuyon	ile, Maide	BC Cab Co en Sumame)	ompany
Mary	nd 2 shoulth and N		19a. Informant's Name/Relationship Ignatius Egbujor		ner		•		et and Number or Ri k Road, R				Zip Code)
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important: If item 27 is any Injury or other tra once.		20a. Method of Disposition  1 ®Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe  21. Signature of Funeral Service Lie	cify)	I B		Cemet 2. Name	ery	lace) 2/9		Por	uneral H	ırt, Nigeria Iome
760,	Physician /Medical Examiner  pe parial-transit	I Examiner	23a. Patr. Erner the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hepat b. Hepat Due to (or Due to (or Hepat	as a consectic Fa	ncephal quence of): nilure quence of):			ying, such as cardia	c or respiratory	v arrest,		Approximate Interval Between Onset and Death
P.O. Box 687	ne death certificate the attending phy: thed for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	2 Feta	al death 3	⊒Ectopic ⊒ Other (				-	23d. Date of del Month	ivery Day Year
	w requires that the bean signed by should be detact	by	Part II. Other significant condition	s contributing to deat	h but not res	sulting in the (	underlying	g cause	given in Part I.				the cause of death?
Division of Vital Records,		Completed								pe 1 ☐ Yes	topsy rformed: s 2\overline{\text{\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\texi}\$\$\$\tex{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$	prior to death?	utopsy findings available completion of cause of 2 ☑ No
fVit	Physicien: 1 this certifical al director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 🛣 Inp	atient 2	] ER/Outpatie	nt 3 🗆 I	DOA	26. Place of De Other: 4 \(\bar\) Nursing I			6 ☐Other (Spe	cify)
sion o	D 5 5	Certification;	27. Manner of Death  1   Natural  2   Accident  3   Suicide  5   Pending investiga  6   Could no	tion		28b. Time of Injury	М	1	Vork? ☐ Yes 2 ☐ No			jury occurred	ural Route Number,
Divi	To the Hospital or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the fun		4 Homicide determin	building,	etc.*(Speci	(fy)				City or	Town, St	ate)	
	he Hosp n 24 hot he Fune pletely fil	Medical		Physicien: To the be xaminer: On the basi and manner	s of examin		rvestigati	on, in m	y opinion, death occ		e, date a	and place, and due	e to the cause(s)
	Tot Tot comp	Σ	29b. Signature and title of certifier  Momas	MD.					00687			Date signed (Mont $1/20/200$	
)_	(3)		30. Name and address of person was Sony M. Thomas					., I	Baltimore,	MD.			
	Sta Regist		31. Date filed (Month, Day, Year)		istrar's Sign	ature	N.						

State of Maryland / Department of Health and Mental Hygiene 2001. 05

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Ž	Examiner	4a Facility Name (If not institution, give stre			4b. City, Town, or Loce		c. County of Deeth	
		CRESCENT CITIES		thday) If Under 1 Year	RIVERDALE  If Under 24 Hrs. 8.		PRINCE GE	
	Funeral Director	5. Social Security Number  0.79-24-7721  Usual Residence of Decedent	7. Age (In yrs. last bin	Yrs. Months Days	Hours Min.	Date of Birth (Month, Dey, Year 6 30 19	26 North	lace (State or Foreign try) Carolina
	yeud wa	10a. State 10b. County	10c. City, Town	n or Location			10	0d. Inside City Limits
	Mary Fied by	MD Prince Geor	rge's	Suitland				1 1 Yes 2 □ No
	r 28s	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Coun	try?
	th wit	3514 Silver Park I	Orive # 3	20746		U.S	.A.	
Maryland 21215-0020	72 hours efter death with the Maryland natural', or ferna 23e or 28e-f show dicel Examine must be notified at steed by Elineral Director		Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - America Black, White, e Specify: Bla	etc.
5-0	n 72 hours of natural, of adical Examples of the house of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the	15. Decedent's Educati (Specify only highest grede co		Decedent's Usual Occup	oation during most of working	16b. I	Kind of Business/Ind	justry
121	led within 72 hours e ygiene. Nor then "netural", o nt, the Medical Even	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	d)		Private	
5	e filed v at Hygie other th	12th 17. Father's Name (First, Middle, Last)		Domestic	18. Mother's Name (F			
and	ld be fill be fill be fill be fill be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be out be	D 711	eiohn			Wilborn	1 Sumame)	
7	should be and Menta marked umartic ev	19a. Informant's Name/Reletionship (Type,		. Mailing Address (Street	and Number or Rural R	Route Number, City	or Town. State. Zip	Code)
Z	nd 2 s lith er 27 ia r trau	Loretta Deal/Daug		514 Silver	Park Dr. #	3 Suitla	nd, Maryl	and 20746
Baltimore,	namit. Peges 1 and 2 should be filed within 72 ho Department of Health end Mental Hygiene, Important: If frem 27 is marked other than "natur Inny Injury or other traumatic event, tra Medical Ince.	20a. Method of Disposition  1XI Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State cemeter	Disposition (Name of y, cremetory or other plane) verton Natio	ce)		ocation - City or To	
Ħ	parmit. Peg Depertment important: i any injury o once.	21. Signature of Funeral Service Licensee	July	22. Name and Addre			s Funeral	
ä	parm Depe impo any i	1 X X II I	$\sim 00$	7474 Land	over Koad I			
		23a. Part1. Enter the diseas , r complication shock, or heart failure.	ions that caused the death. Do rause on each line.	1				Approximate Interval Between
	Physician /Medical	Immediate Cause (Final		c: = 00 :	^		į	Onset and Death
14	Examiner	disease or condition resulting in death) a	SEPTI	CEMI	H.		İ	
	ةِ الكام	<u> </u>	Due to (or as e	consequence or):	20001		1	
	axecuted In and hial-transit	b. —	Due to (or as e	consequence of):	210017		A .	
Ó	e axe	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying (Cause (Disease or injury c	Cerebraso	2 I anda	r acc	id en	t	
68760,	certificate be axecuted nding physician and use es the burial-transit	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):	and the same			
Box	death ceine attendir							
P.O.	D 0 0 -	Part II. Other significant conditions contrib	uting to death but not resulting in	the underlying cause giv	ven in Part I.			the cause of death?
						1 🗆 Yes	2□ No 3□ Prob	ably 4 Unknown
of Vital Records,	been s should					24a. Was an auto performed?	ava con	ere autopsy findings nilable prior to npletion of cause death?
Re	The law ate has bege 2 s					1 ☐ Yee 2		Yes 20 No
ta	certificate rector, per				26. Place of Death (C		1	7700 234110
$\geq$	Physician: rthis certific iral director.	examiner?	oital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3 DOA Oth	ner:		6 □Other (Specify	')
ou o	Attending Physic death.  actor: After this by the funeral diffication: To		8a. Date of Injury 28b. T	njury Wor		l. Describe how inju		
Division	tal or Attending P is after death.  al Director: After tied in by the funers Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f.	Location (Street a. City or Town, State	ind Number or Rural le)	Route Number,
_	Hospi 24 hou Funer taly fill		n: To the best of my knowledge On the basis of examination end and manner steted.	death occurred at the tire	me, date and place, and ppinion, death occurred	due to the cause(s at the time, date an	and manner as stand place, and due to	ated. the cause(s)
_	within 2 To the compla			29c. Licens	se number	29d. Da	ate signed (Month, E	Day, Year)
	->	1 Jana		NU	8077	5	1210	11
2	(1)	30. Name and address of person who comp	eted cause of death (Item 23a) (	Type, Print)	XANDER	ET	ILLA	t. vin
	6	7676, NEW HAN		E. #210	LANGE	EYPAR	K MO	20912,
	State		32. Registrar's Signature	rede				

State of Maryland / Department of Health and Mental Hygienes 05256 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2004 11:15 A. February Marion Louise Evans /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) 12/15/21 Birthplace (Stete or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months 1 M 2 X 577-54-1925 Wash., D.C. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County or 28a-f show the Medical Exeminer must be notified at D.C. Washington Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1010 Ft. Lincoln Dr., N.E. # 1009 20018 U.S.A. 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Rece - American Indian, Black, White, etc. teme! 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 naturel', or 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within in and Mental Hygiene.
7 le marked other then \*r Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas A. Payne Blanche Louise Lewis ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sh ment of Health and tent: If item 27 le n Blanche M. Hickman/Daughter 6357E 64th Ave. #E-6, Riverdale, Md. 20737 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 0 Chesapeake Crematory, Inc. 2/7/04 Beltsville, Md. permit. Page Department Importent: If eny injury o \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc. any W 4925 Burroughs Ave., N.E., Wash., D.C. 23a. Part1. En er the disease, or complications that caused the death. shock, or heart failure. List only one cause on each live. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intarval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or # mendey melastan Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physician Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown The law requires that the 9 Unknown been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying caope given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 🗆 No 2 No 1 Tyes Division of Vital the Hospitel or Attending Physician: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. s after death 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide filled 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner etated. 29a. Certifier completely within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature d title of certifier 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20912 7610 CARRELL ANG Q MASREGN 31. Date filed (Month, Day, Year) State FEB 0 6 2004 Registrar

			1- State of Maryland	d / Depa <i>Cer</i>	artment of He tificate of D	ealth and M Death	lental Hyg	giene 2004	05257
ŀ	Physici		1. Decedent's Name (First, Middle, Last)  Richard Harry Elliott, Sr.				2. Date of Dea Month Jan. 3	Day 2004	3. Time of Death
	/Medio Examin		4e. Fecility Name (If not institution, give street and number)  14210 Carvel Manor Circle		4b. City, Town, or Eden			4c. County of Deat	
ı	Funeral Director		5. Social Security Number  222-18-3366  Usuel Residence of Decedent	rst birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 4-2-193	(Yeer) Co	nplace (State or Foreign untry)  Md •
	death with the Maryland ms 23a or 28e-f show	tor		Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes ※※ No
	with the	i Director	10e. Street and Number 14210 Carvel Manor Circle		10f. Zip Code 2182	2	1	Og. Citizen of What Co USA	untry?
20	be tiled within 72 hours atter death with the Marylan tal Hygiene. d other than "natural; or Itams 23s or 28e-f show event, Its Medical Exacting must be collified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S. Armed Forces?		Was Decedent of His f Yes, specify Cubar I ☐ Yes 2X No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	
213-0030	thin 72 hour e. en "natural Medical E.	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Deced (Give life. I	ient's Usual Occupa kind of work done d DO NOT use retired)	uring most of worki	ng	16b. Kind of Business/	ndustry
and 21	be tiled within 72 ntal Hygiene. ed other than "nai event, in Medic	Be	17. Father's Name (First, Middle, Last)  Jack Elliott	Yard		18. Mother's Name		concrete Maiden Sumame) 211 Elliott	company
maryian	nd 2 should be Ith and Mental 27 is marked of traumatic eve	2	19a. Informant's Name/Relationship (Type, Print) David Elliott, Son			nd Number or Rura	I Route Number	r, City or Town, State, 2	(ip Code)
bailmore, i	Hea The		20a. Method of Disposition 20b. Pl	ace of Dispo	sition (Name of natory or other place).ens Cem.	9)	Date	20c. Location - City or Delmar, DE	
Dail	permit. Peges Department of I Importent: If Ite any Injury or of		21. Signature of Funeral Service Licensee	22 S	Name and Address hort Fune 3 E. Grov	s of Facility ral Home	, Inc.	e. 19940	
	Physician		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	Do not ent	er the mode of dying	, such as cardiac o	r respiratory arr	est,	Approximate Interval Between Onset and Death
,00/g	death certificate be executed e attending physicien and id for use as the burial-fransit	dicai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of th	ence of):	Antery	disea	مند		
O. BOX 6	he death certific: the attending pl thed for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetel 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
Ľ	The law requires that the de ite has been signed by the a bage 2 should be detached t	ed by Ph	Part II. Other significant conditions contributing to death but not result to per Chole Stewlernce	lting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contribute to	the cause of death?
vital necords,		Completed by					24a. Was a autops perform	med? prior to death?	topsy findings available completion of cause of
	ysicien: Th is certiticate director, pag	o Be	25. Was case referred to medical exampler?  1 ØYes 2 No  Hospital: 1 Inpatient 2	R/Outpatien	it 3□ DOA Othe	26. Place of Death		ence 6 Other (Spec	nifu)
DIVISION OF	£ 5 =	⊢		28b. Time of Injury	28c. Injury Work			ow injury occurred	,
DIVIS	tel or Attending P rs atter death. et Diractor: Atter t ed in by the tunera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hobuilding, etc. (Specify	me, farm, str )	eet, factory, office		28f. Location (S City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospitel c	Medical	29a. Certifier (Check only one)  Certifying Physician. To the basis of examinat and manner stated.	ion and/or in	vestigation, in my op	inion, death occurr	ed at the time, d	ate and place, and due	to the cause(s)
	Total Eos	2	29b. Signature and Aitle of certifier		29c. License	53394	2	2/2/0	n, Uay, Year)
1	00		30. Name and address of person who completed cause a death (Item	23a) (Type,	Print)	2000	807		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  FFR 0.3 2004  32. Registrar's Signat	ure &	Sparks	/	t		

			For State Registrar	State of Maryla	nd / Depa	artment of h tificate of	Health and I	Mental Hyg	iene <mark>20</mark> 0	e. 4 052	58
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  JOSEPH JAM	IES ENNIS	<b>,</b>			2. Date of Deat Month	h Day Yo	3. Time of D	Death
	Examir		4a. Facility Name (If not institution, give s PENINSULA REGION	treet and number)	Centre	4b. City, Town, o	SAUIS6	1	4c. County of	Death Pomics	
	Funeral Director		5. Social Security Number 6. Sex	M 2□ F 7. Age (In yrs		If Under 1 Year Months Days		8. Date of Birth (Month, Day, November	Year) 9.	Birthplace (State or a Country) Maryland	Foreign
	death with the Maryland ms 23a or 28a-f show I must be notified at	ctor	10a. State 10b. County  Maryland Wicomico		ity, Town or Lo					10d. Inside City 1 X Yes 2	
	th with th	I Director	10e. Street and Number 106 Jerome Drive			10f. Zip Code 218	804	10	0g. Citizen of Wha	t Country?	
36	rs after death with I', or Items 23a or	by Funeral		2. Was Decedent Ever in U Armed Forces? 1 XYes 2 No Ar If Yes, Give 1950 Year or Dates:	1 1		Hispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race -	American Indian, White, etc. White	_
205 - 505 - 505 1215-00	within 72 hours after ene. than "natural", or Ite the Modical Examina	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Deced (Give life. L	O NOT use retired	,			ess/Industry , Heating	&
d 7 6	TO 70 = ***	Be Cor	12 17. Father's Name (First, Middle, Last)	-	Mast	er Plumb		ne (First, Middle, N	Air Cond	itioning	
bh ylan	should be nd Mental marked c	To B	Goerge Washington	Ennis			Orpha H	Beatrice	Beam		
18-18-1, Mary	s 1 and 2 should be filer f Health and Mental Hyg item 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship (Type Mildred T. Ennis	/wife	106	Jerome	and Number or Ru Dr., Sali			e, Zip Code)	
Baltimore,	permit. Pages 1 Department of He Important: If iter any injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval nom otate		sition (Name of latory or other place OVE Ceme		Date 2 29/04	Parsons	or Town, State	
Bali	Depart Import any in		Stockling of Funeral Service Licenses		22 H S P 5	Name and Addre Olloway Ol Snow	ss of Facility Funeral A Hill Rd.,	Home Prof	essional	Associati 1804	ion
•	Prrysician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	dions that caused the deal cause on each line.  Due to (or as a consec	th. Do not ente	or the mode of dyin	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Betwee Onset and De-	en eath
8760,	le be ysicia e bur	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consecutive to (or as a consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive to consecutive					12-12-		
P.O. Box 68	Attending Physician: The law requires that the death certifical redeath. sctor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ıl death 3 ☐	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Yea	ar
ords, P	w requires that been signed b should be deta	ed by P	Part II. Other significant conditions cont	ributing to death but not res	ulting in the un	derlying cause giv	en in Part I.	-	_	e to the cause of deal	
Division of Vital Records,	ysician: The law r is certificate has be director, page 2 sh		/			·		24a. Was an autopsy perform	ed? prior	autopsy findings ava to completion of caus 1? 'es 2 \( \text{No} \)	ailable se of
XX	sician: Th s certificate lirector, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	spital:	ER/Outpatient	all post Other		h (Check only one			
ion of	nding Phys ith. :: After this e funeral di	atlon: T	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	3 DOA 28c. Injun Work		me 5 Resider 28d. Describe hov		p <del>e</del> cify)	
Divis	al or Attens s after des il Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre y)	et, factory, office		28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number	r,
	To the Hospital or Attending Pheibin 24 hours after death. To the Funeral Director: After the impleately filled in by the funeral	Medical (	29a. Certifier 1/2 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my kno or: On the basis of examina and manner stated.	owledge, death tion and/or inve	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the cau red at the time, dat	use(s) and manner e and place, and c	as stated. lue to the cause(s)	
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ITIVA	0	-	30. Name and address of person who com	pleted cause of death (Item					1 4		£ 7
	Sta Registra		31. Date filed (Month, Day, Year) JAN 28 200	32. Registrar's Signa	iture &	Spork	2	3	19 200	my res ne	80 (

State of Maryland / Department of Health and Mental Hygiene 2004 05259 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:00 A M January 25 2004 Lillian Pearl Francois /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Lanham Doctors Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1□M 2፟MF 88 14, 1915 Louisiana Mar. Director 360-05-3115 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show 1 XYes 2 No District of Columbia Washington Direct 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 20018-2018 United States 1500 Evarts St., N.E. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status e filed within 72 hours after de Il Hygiene. other then "naturel", or item Black, Wille rig can the Medical Exertitival 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: American þ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Librarian Government nd Mental Hygie marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fill of Health and Mental H itam 27 is marked other other traumatic even Be Laurence Cunningham, Jr. Rachel L. Pearce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Evarts St., N.E. Wash., DC 20018-2018 Honore L. Francois - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit Pages 1
Department of He
Important: If itan
any in ury or oth 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/4/2004 Lee's Crematory Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 onno sour M Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Months Immediate Cause (Final disease or condition resulting in death) Metastatic Carcinoma Right Femur **Physician** /Medical Due to (or as a consequence of): Examiner 4 Months Extensive Skeletal Metastases Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed 40 Years Breast Cancer Primary burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 X No Systolic Hypertension, Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Degenerative Joint Disease-Lumbo Sacral Spine, certificate has page 2 autopsy performed? 2 🗌 No 1 Tes 1 Yes 2 No Rheumatic Heart Disease Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 x Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√2 No Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? or Attending Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Hospital 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated. within 2 To tha 29d. Date signed (Month, Day, Year) 29c. License number MD. 10033503 January 25, 2004 this mannith 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9470 ANN APOLIS 20 # 301 LANHAM 30706 KRISH NAMULTHY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2004 Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2004 05260 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9:35 A M Feb. 1, 2004 **Physician** Marjorie Fairbanks /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner National Lutheran Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 476-26-9988 1 ☐ M 2 🖫 F 72 Yrs. Director Apr.10,1931 Minnesota Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23e or 28e-f show Md. XXYes 2 □ No Montgomery Rockville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9701- Veirs Drive 20850 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) School Teacher yrs. Education other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marred oth any lipity or other treumatic event 2008. Carl Bornhausen Minnie Hansen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr.John Fairbanks-Husband 4717-Jasmine Dr., Rockville, Md. 20853-1740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State All Souls Cemetery-2/6/2004 Germantown, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hysong Co., Inc. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician 10515 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner numonia Sequentially list conditions, if any, leading to miniadiate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner sician and burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ed by the attending phys detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death To the Hospitel or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 2004 D 5006/2 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMUEL G. MALLER M.D. -9701- Veirs Dr., Rockville, Md. 31. Date filed (Month, Day, Year) 82. Registrar's Signature State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 05261 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Fletcher Charles 7:29 P 2004 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 ☑ M 2 □ F 58 Yrs Director 213-46-9785 July 26 1945 <u>Maryland</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Itams 23a or 28a-f ahow 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 9122 Washington Avenue U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Black. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 'Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sanitation Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John W. Fletcher Sarah Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Curry/Sister 1204 Elsa Avenue Landover, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ò 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny injury or once. Resurrection Cemetery 2/4/2004 Clinton, Maryland A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician aCardiac Arrest /Medical resulting in death) Due to (or as a consequence of): Examiner Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Hypertension and Due to (or as a consequence of): P.O. Box 68760. the attending physician use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day detached for Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Hinknown þ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, should be Chronic Kidney Failure 1 Yes 2 No 3 Probably 4 Dunknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes or Attending Physician: ours after death.

eral Director: After this certifical filled in by the funeral director. 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🛂 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1/29/04 duce D0020752 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel A. Nash, Jr. M.D., 6196 Oxon Hill Rd. 31. Date filed (Month, Day, Year) #300, Oxon Hill, MD 20745 32. Registrar's Signature State FEB 04 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05262 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 02/02/2004 Marion Franklin 5:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HCR Manor Care of Hyattsville Hyattsville Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/15/1962 9. Birthplace (State or Foreign **Funeral X**2XM 2□ F 417-96-7034 Director 41 Alabama Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, the Medical Examinational be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 □ No Directo D/C N/A Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 803 D Street N.W. 20011 Apt. #1 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2X No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2/OXNo Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 4 College (1-4or 5+) Elementary/Secondary (0-12) Counselor Non-Profit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johnnie Franklin Mary Blackmon ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12411 Lampton Lane Ft. Washington, Maryland 20744 Michelle Wilson / Sister 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 CCremation 3 ☐ Removal from State 02/05/2004 Kalas Crematory Edgewater, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility orge P. Kalas Funeral Home P.A. 21. Signature of Funeral Service Licenses also 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** AIDS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No 2 No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2∭ Vo 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Watural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral C 1 CxCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 4, 2004 D0056414 30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print) JóceÍyn Nazaveno El-Sayed, MD, MPH 6900 Riggs Road Hyattsville, MD. 20783

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 6 2004

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician**  $A_{M}$ ODESSA FARRARE 26 2004 9:30 MAE January /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mallard Bay Nursing & Rehab. Center Cambridge Dorchester 8. Date of Birth (Month, Day, Yea July 7, 19 ff Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign Country) Maryland 5. Social Security Number 6. Sex **Funeral** 1 M 2 TXF 71 217-28-3135 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. fnside City Limits r than "natural", or items 23a or 28a-f ehow the Medical Example must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Dorchester Vienna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4825 Old Route 50 21869 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status 14. Race - American Indian Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Shoe Clerk Leggett's Dept. Store 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be f. Department of Health and Mental in Important; if Item 27 is marked ott any rijury or other traumatic avenant. Be Elmer E. Jackson Della V. Johns 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne F. Sampson/daughter 4825 Old Rt. 50 - Vienna, Maryland 21869 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/02/2004 | Hurlock, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran's Cem. 21. Signature of Funeral Service License 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21801 JOLLEY MEMORIAL CHAPEL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No Hospital or Attending Physicien: nerel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☐No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Vkhammad Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 2 9 2004

•	3		1 - For Amended #19a&I	State of M	larylan FH	d / Depa	artmei rtifica	nt of H	ealth a Death	ind Me		iene 2	004	05264
			1. Decedent's Name (First, Middle, Last							- 1	2. Date of Dea	th Day	Year	3. Time of Death
	Physicia /Medic		George Walter Gos	sard							Februa		2004	0930 M
	Examin		4a. Fecility Name (If not institution, give	street and number,	)		4b. City	, Town, or	Location o	f Death			inty of Death	
			Washington County	Hospita	1			agers					shingt	
	Funeral Director		5. Social Security Number 6. Se 216-22-9223	x 7. A	ge (In yrs. 77	last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day NOV . 6,	1926	Coun	lace (State or Foreign try) nsylvania
	P .		Usuel Residence of Decedent  10a, State 10b, County		10c Cit	y, Town or Lo	cation						11	0d. Inside City Limits
	anyla ehov	5		4										1 ☐ Yes 2 🖾 No
	Ba-f	Director	MD Washing	con		lagerst		p Code	<u> </u>		1	On Citizen	of What Coun	trv?
	with		10e. Street and Number 11204 Pepperbush	Circle.	Ant.	104	101.2	2174	.0			US		,
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36	d within 72 hours after death with the Maryland jiene. I then "natural", or lteme 23e or 28e-f ehow The Musical Exacular Innat to rotilled at	by Funeral	1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces  1  Yes 2  If Yes, Give Year or Dates:	?  No		f Yes, sp 1 ☐ Yes	ecify Cubai	Specify:	Puerto R	ican, etc.)		Black, White, o ecity: Whit	
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215	within 7 ene. then "n	ple	(Specify only highest grad Elementary/Secondary (0-12)	e completea) College (1-4or	5+)	life.	DO NOT	use retired	uring most	or working	1			
21	filed within Hygiene. other then '	Completed	12			Area	Comm	and (	Chief			U.S.	Army	
b	e filed at Hygie other	0	17. Father's Name (First, Middle, Last)								(First, Middle, I		name)	
lar	Aenta Aenta rked tic ev	To B	Earl F. Gossard						Este	ella	I. Bend	hoff		
Maryland 21215-0036	les 1 and 2 should be filed of the soft has that he soft has the soft her if item 27 is marked other to ther traumatic event, in	0	19a. Informant's Name/Relationship (7) Donald R. Gossa Ceorge R. Cossa	rd. Sr.	r						Route Number lagerst Willian			
Je,	s 1 ar f Hea item othe		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of		Da			on - City or To	
9	Pages nent of h ant: If ite ury or of		1 ☐ Burial 2 🛣 Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)		9 .	thsbur		-		2/9/0	4	Smith	sburg,	MD
Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Sergic Lious		_	2:	2. Name a	nd Addres	s of Facility	Rest	Haven	Funer	al Cha	pel D 21742
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E	Dhusisian		shock, or heart failure. List only of Immediate Cause (Final			non	1							Onset and Death
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of	Phy or this eral o	<b> -</b>	27. Manner of Death	28a. Date of Ini	urv	28b. Time o		28c. Injury Work			d. Describe ho			,
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/ISI	l or Attending after death. Director: After in by the fune	flca	3 Suicide 6 Could not be	28e. Place of Ir	njury - At h	ome, farm, st	eet, facto	ry, office		28			imber or Rura	l Route Number,
Ö	after Direct	Certification:	4 Homicide	building, e	etc. (Specif	<b>Y</b> )					City or Town	i. State)		
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	ledical (	29a. Certifier 1 Certifying Phy (Check only one)		of examina									
	To the within 2 To the Comple	Me	29b. Signature and title of certifier				2	c. License	number		2	9d. Date sig	gned (Month, I	Dey, Year)
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	4X,		30. Name and address of person who c	ompleted cause of	death (Iter	n 23a) (Type.	Print)					1		1
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É	Sta	te	31. Date filed (Month, Day, Mean		trar's Signa	ature	1	1.	7			1	V	
	Registr		1 1.0 0 4	1004	Eres	13. 16	park							

State of Maryland / Department of Health and Mental Hygiene 2004 05265 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:36 a<sup>™</sup> January 30 Donald Edward Goodwin 2004 /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Carroll Hospital Center Carroll Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 🛣 M 2 🗆 F 83 Jan 09 1921 MD Director 220-03-8466 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Madical Exeminational be notified at 1 NYes 2 □ No Funeral Director Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 504 Poole Road 21157 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 Elementary/Secondary (0-12) College (1-4or 5+) 12 Don's TV/Appliances Owner/Operator 18. Mother's Name (First, Middle, Meiden Sumame) and at of Health and Mental Hy If Item 27 is mark-17. Father's Name (First, Middle, Last) Be Charles E. Goodwin Effie Robertson Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ella Goodwin/wife 504 Poole Road Westminster, MD 21157 permit. Pages 1 an Department of Heal-Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 02/02/2004 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Taylorsville UMC Cemetery Taylorsville, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pritts funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) provascular Week **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and s the burial-transit certificate be executed Examl Due to (or as a consequence of) Physician/Medical as been signed by the attending a should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate of Vital 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA P funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the l Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after within 24 hours a
To the Funeral I
completely filled 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature, and title of certifier 52035 2004 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMINICHE MO 21157 Stores 291 BINU CHACKE Monre 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Sporte FEB 0 2 2004 Registrar

DHMH 17 Rev 1/2001

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes A. A.

		1 - For State Registrar	tate of Marylan	a / Depa	tificate of L	eaith and N Death	nentai Hygi	ene2004	05266
Physi	ician dical	1. Decedent's Name (First, Middle, Last)  Anne Morris Gerrity					2. Date of Death Month January	Day Year 30, 2004	3. Time of Death 6:20 p M
Exan Funera Directo	niner	4a. Facility Name (If not institution, give street  Laurel Regional Hos  5. Social Security Number 6. Sex		last birthday) Yrs.	4b. City, Town, or  Laure1  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 5,	4c. County of Death Prince Ge Year) 9. Birth	1
D		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation		Jan. 3,	1921 Felli	10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show	Director	Maryland Prince Geo  10e. Street and Number  5713 Pontiac Street	rge's Be	rwyn H	10f. Zip Code			g. Citizen of What Co	1 ☑ Yes 2 ☐ No untry?
P 25 B	by Funeral	11. Marital Status 12.	Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		20740 Vas Decedent of Hir Yes, specify Cubar □ Yes 2∑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:		. S . A .  14. Race - Amer Black, White Specify: Wh	
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yidild build be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last)  John P. Morris  19a. Informant's Name/Relationship (Type,	Orint)	10h Mailie	- Address /Street	Teresa	e (First, Middle, M	ey	- Co-tol
the al		Thomas M. Gerrity -	Son 20b. P	17316		a Loma,	Fountain	City or Town, State, Z $ ext{Hills.AZ}$ Oc. Location - City or 1	85268
permit. Pages 1 are Opportunit. Pages 1 are Opportunit: If Item any injury or other	DUCE.	1 ⊠ Burial 2 ☐ Cremation 3 ☐ Remote 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Gat		. Name and Addres		sch's Fu	Silver Spr neral Home sville, MD	, P.A.
fileste be executed  Wedicz Bybysician and as the burial-transit	Examiner	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the		n. Do not enter Heart uence of): diomyo uence of]:	er the mode of dying Failure				Approximate Interval Between Onset and Death
ath certif	Physician/Medical	in the past 12 months?	If yes, outcome of pregna 1 □ Live birth 2 □ Feta. 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of delik	very Day Year
w requires that the desibeen signed by the a	þ	Part II. Other significant conditions contrib	uting to death but not resi	ulting in the ur	derlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
The law ate has b page 2 sl	Completed	Acute Renal Failure					24a. Was an autopsy performe	ed? prior to death?  →No 1 □ Yes	opsy findings available ompletion of cause of 2 No
Phy 9	cation: To Be	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	ital: 1 fnpatient 2 18a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursing Ho	n (Check only one, me 5 ☐ Residen 28d. Describe how	ce 6 □Other (Speci	fy)
pital or ours afte eral Dir filled in	al Certification:	4   Homicide	8e. Place of Injury - At ho building, etc. (Specify	() 			City or Town,		
To the Hos within 24 hr To the Fun completely	Medical	(Check only 2 Medical Examinant one)  29b. Signature and title of certifier  30. Name and address of person who comp	On hielbasis of examina and manner stated.	tion and/or inv	estigation, in my op	inion, death occurr	ed at the time, dat	e and place, and due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due of the due o	o the cause(s)
	State strar	Ikechi F. Okwara, M 31. Date filed (Month, Day, Year) FFR 0 2 2004		enbelt	Road, #U-	-15, Coll	ege Park	, MD 20740	-2347

State of Maryland / Department of Health and Mental Hygiene 2004 05267 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29, **Physician** Month 2004 Edwin Roland Garrett January 7:15P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 6. Sex. 12 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Washington, DC 579-24-9919 Director Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10d. Inside City Limits Yes 2 No La Plata Maryland Charles Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 USA 616 B Zekiah Run Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2XXNo 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vivian Roland Edwin W. Garrett I. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9905 Sudan Place Upper Marlboro, MD. 20772 Robert Garrett/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

'4 ☐ Donation S ☐ Other (Specify) 1/30/04 Edgewater, MD. Kalas Crematory 21. Signature Funeral Service Licensee 22. Name and Address of Facility Geo. P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 100000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∭ No this I Diractor: After this d in by the funeral d 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To tha Funeral Dirac completely filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46478 .30.04 30. Name and address of person to completed cause of death (Item 23a) (Type, Print) surrents Red clim ten mys desure ha-rode an, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		State of Maryland / Department of Health and Mental Hygiene Certificate of Death  Certificate of Death  State of Maryland / Department of Health and Mental Hygiene 2004 0526
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Hazel Goodman  2. Date of Death Month Day Year  January 27 2004 1:06 P
Examin Funeral Director	er	Washington Adventist Hospital  5. Social Security Number  5. Social Security Number  6. Sex  1
Q	ector	Usual Residence of Decedent       10a. State     10b. County     10c. City, Town or Location     10d. Inside City Limit       Maryland     Prince George     Adelphi     XX
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Department of Heatil and Mental Hygiene. Important: If tem 27 is marked other than "natural", or iteme 23a or 28e-f show mit injury or other traumatic event. It is Modical Examiner must be notified at once.	Funeral Director	1836 Metzerot Road #620  20783  United States  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
within 72 hours one. ene. than "natural", the Modical Ex.	Completed by	3 ☑ Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Sixth  1 □ Yes 2 ☑ No Specify: Specify: Black  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Domestic  Private
should be filed with ind Mental Hygiene, i marked other thai umatic event, the h	To Be Co	17. Father's Name (First, Middle, Last)  Charlie Ballinger  18. Mother's Name (First, Middle, Maiden Sumame)  Rose Thompson  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
permit. rages i end z sik Department of Health and Important: If item 27 is m any injury or other traum once.		Lottie Bradsher/Daughter  3404 Toledo Terrace #G-1, Hyattsville MD 207R2  20a. Method of Disposition  1   XBurial   2   Cremation   3   Removal from State
permit. Fa Departmen important: any injury		14 Donation 5 Other (Specify) Harmony Memorial Feb 2,2004 Landover Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert G. Mason Funeral Home 1661 Good Hope Rd SE, Washington DC 20020
Asician and Asician and Parial-Iransit	cal Examiner	23a. Part1. Enter the discrete fine discrete fine discrete fine fine see, or complications that can see when death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset
that the death certilicate be executed ed by the attending physician and detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
seen sign	leted by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death  1   Yes 2   No 3   Probably 4   Unknown of the underlying cause given in Part I.  24a. Was an 24b. Were autopsy findings available.
is certificate has t	Be	autopsy performed?  1   Yes 2 2 No   1   Yes 2   No    25. Was case referred to medical examiner?  Hospital: The state of Death (Check only one)  Hospital: The state of Death (Check only one)
this ald	Certification; To	27. Manner of Death 1 \( \) Inpatient 2 \( \) EP/Outpatient 3 \( \) DOA 4 \( \) Nursing Home 5 \( \) Residence 6 \( \) Other (Specify)  27. Manner of Death 1 \( \) Natural 5 \( \) Pending 2 \( \) Accident investigation 2 \( \) Accident 6 \( \) Could not be
it of the trospitel of Attending within 24 hours affer death.  To the Funerel Director: After completely filled in by the funer	al Certifi	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28g. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
within 24 h To the Ful completely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
Sta Regist	ate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. MASREEN KANGO 7610 CARROLLAVE. TAKOMA PARK Md.,  31. Date filed (Month, Day, Year)  32. Registrar's Signature  FFB 0 2 2004

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🤈 05269 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ROSE M. GREEN 11:10 P 31,2004 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Forest Glen Nursing Home Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛛 F December 21,1938 Wash. 578-52-4219 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b County 10c. City. Town or Location worle the Medical Examiner must be notified at 1 Yes 2 No Director Prince George MD Suitland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 3407 Navy Day Drive 20746 USA death 1 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖺 No 11. Marital Status Black. White, etc. within 72 hours after 1 X Never Married 2 ☐ Married ö Maryland 21215-0036 Yes, Give ear or Dates: 1 ☐ Yes 2 X No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced naturai Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Gov't. Computer Analyst it of Health and Mental Hyg If item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Geneva Herbert Lawrence F. Green 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Berry/Son 3543 Terrace Drive Apt.A Suitland, MD 22074 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or Cedar Hill Cemetery 02/05/2004 Suitland, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 21. Signature of Funeral Service Lice DCe 4111 Pennsylvania Avenue, Suitland, MD 20746 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Stomach Cancer unknown resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any leading to in reclaid cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2 No 1 Yes 2 No 1 Tyes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled in 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) certific 29c. License number 29b. Signature and title of eburay, 3, 50 npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who Arastoo Yazdani 9801 Georgia Ave. #341 Silver Spring, MD 20902 .D. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/200

Registrar

2004

State of Maryland / Department of Health and Mental Hygiene 21 05270 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year THERESA 8:13PM GREENE LAWUAKX 20 /Medical 2004 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Doctors Community Hospital Lanham Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 23, 1961 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2X F 578-90-1026 42 Director Wash.D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at MD Prince George Bowie X□Yes 2□No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 4802 Lake Ontario Way 20720 U.S.A. death Funerai 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married Married ☐Yes 2 🔯 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced Specify: Black ear or Dates: "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer 4 Centech Co. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other treumatic event 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be Melvin Newman Marie Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick R.Greene-Husband 4802 Lake Ontario Way, Bowie, MD. 20720 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Fort Lincoln Cem. Jan. 27,04 Brentwood, MD 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hunt Funeral Home 21. Signature of Funeral Service Licensee Francis 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical **Examiner** tolid Hata Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed physician are the burial-t Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death Month Day Year 5 Other (specify) ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 ₽No 3 Probably 4 □Unknown 1 TYes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 200 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? After 28d. Describe how injury occurred Injury 1 ANatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Telle, ms 146895 22/04 lì0 ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person JIMA 122848 3710 LIVERIA STREET SOITE & C TEMPLE HILLS MD 31. Date filed (Month, Day, Year) State Registrar 2004

RKD			1. For Unpend Item #23a. Registrar	State of Mary	land / Dep me G828	partment	of Health a	and Mental Hyg	iene 2004	05271				
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  WILLIAM JOHN	GROW				2. Date of Deat Month JANUARY	3	3. Time of Death 1:41P. M				
	Examir	ner	4a. Facility Name (If not institution, give s ATLANTIC GENERAL H	OSPITAL		BERLI			4c. County of Death WORCESTER					
319	Funeral Director		5. Social Security Number 6. Sex 164–46–8614	7. Age (In 4.	3 Yrs. last birthda		Year If Under Days Hours	24 Hrs. 8. Date of Birth (Month, Day, 12 - 17)	Year) 9. Birth Cou	place (State or Foreign intry) PA				
	ith the Maryland or 28a-1 show	tor	10a. State 10b. County  DE SUSSE		c. City, Town or	Location SBOR	٥			10d. Inside City Limits 1 ☐ Yes ※ No				
	ath with the 23a or 28a	ai Director	10e. Street and Number RT / Box 70	DAI		10f. Zip C		10	Og. Citizen of What Cou	intry?				
036	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f show ha Madical Examinat must be multiwed at	by Funeral	11. Marital Status  1 □ Never Married Ž⊠ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 X Yes 2 □ No 1f Yes, Give Year or Dates:		. Was Deceder If Yes, specify	Cuban, Mexican	gin? (Specify Yes or No., Puerto Rican, etc.)	14. Race - Amer Black, White Specify:					
Maryland 21215-0036	within 72 hours sne. than "natural", te Medical Exa	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a Dec	^	done during most retired)	of working	6b. Kind of Business/Ir	,				
land 2	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, the Market	To Be Co	17. Father's Name (First, Middle, Last)  JOHN G GRO	ma N	18. Mothe	SELF EMPLOYED  er's Name (First, Middle, Maiden Sumame)  LAIRE KURZ								
e, Mary	s 1 and 2 should be filed within 72 hr Health and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the Medical		19a. Informant's Name/Relationship (Typ. DEBRA EFFINGER	r or Rural Route Number,	al Route Number, City or Town, State, Zip Code)									
Baltimore,	Page tment o tant: If jury or		20a. Method of Disposition  1 Burial Cremation 3 Re  4 Donation Other (Specify)	emoval from State	REMATOR	omatory or other	LMARYA	1/28/04	Oc. Location - City or To	DE				
Ba	permit. Departr Imports eny inji		21. Signature of Funeral Service Licensee  2. Name and Address of Facility BENNIE SMITH FH  23a. Part. Enter it disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate											
8760,	Physician /Medical Examiner with parial-transit	dical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  d.	CARDIAC AR  Due to (or as a cor  Due to (or as a cor	nsequence of):					Interval Batween Onset and Death				
Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of prince 1 Live birth 2 4 Pregnant at time		23d. Date of delive Month	ery Day Year							
ords, P	w requires that been signed b should be deta	ted by Pl	Part II. Other significant conditions cont FATTY LIVER	ributing to death but not		cco use contribute to the	1.2							
ai Reco		Completed by						24a. Was an autopsy performe 1X Yes 2	prior to coi death?	psy findings available inpletion of cause of				
Division of Vital Records, P.O.	ng Phys dter this ineral dir	ation: To Be	25. Was case referred to medical examiner?  1 X Yes 2 No  27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	ospital: 1  Inpatient 28a. Date of Injury (Month, Day Yea	2 XER/Outpatie 28b. Time o Injury			of Death (Check only one) sing Home 5  Residen 28d. Describe how	ce 6 Other (Specify injury occurred	<b>(</b> )				
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	27. Manner of Death 1 XX Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Describe how injury of Injury 28b. Time of Injury M 1 Yes 2 No 28b. Describe how injury of Injury M 1 Yes 2 No 28c. Injury at Work? 28b. Describe how injury of Injury At home, farm, street, factory, office 28c. Injury at Work? 28b. Describe how injury of Injury At home, farm, street, factory, office 28c. Injury at Work? 28b. Describe how injury of Injury At home, farm, street, factory, office												
	the Hosp nin 24 ho the Fune npietely fi	Medical	one)	cian: To the best of my er: On the basis of exam and manner stated.	knowledge, dea nination and/or in	ivestigation, in i	my opinion, death	place, and due to the cau occurred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)				
	To To Con	-	100:	Cil		0	.C.M.E.		Date signed (Month, I					
			30. Name and address of person who con	9			nn Stree	t, Baltimore	e, Maryland	21201				
	Sta Registra		31. Date filed ( <i>Month</i> , <i>Day</i> , <i>Year</i> )  JAN 2 8 2004	32. Registrar's S	ignature	Spar	les							

			1 - For State Registrar	State of M	/larylai				ealth a				200	L 05	272
47	Dhusisi		1. Decedent's Name (First, Middle, Las	t)							2. Date of De			3. Time	of Death
	Physici /Medi		Anna	К.		Hentis	h				Januar				45P M
	Examir	ner	4a. Fecility Name (If not institution, give		•	_			Location of			4c.	County of De		
	<u> </u>		Montgomery Village 5. Social Security Number 6. Se				Mon If Under		ery \				Montgo		
۲	Funeral Director			M 2⊠F	91	. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da	y, Year)	9. 8	irthplace (State Country)	or Foreign
			Usual Residence of Decedent		91						Jan. 1	1, 19	913 0	kraine	
	how		10a. State 10b. County		10c. C	ity, Town or Lo	calion							10d. Inside	City Limits
	e Ma Se-1 s	cto	Maryland Montgome	ry	Mo	unt Ai	ry							1 🗆 Ye	s 2X No
	dit the or 24	Directo	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of Whai (	Country?	
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	lter de	Funeral	11. Marital Status  1 □ Never Married 2 □ Marned	12. Was Deceder Armed Force 1 Tyes 2	5?	J.S. 13. V	Yas Deced Yes, spec	dent of Hi city Cuba	spanic Ori n, Mexican	gin? (Spi 1, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - An Black, Wh	nerican Indian, nite, etc.	
336	ors af	by F	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates	_	1	☐ Yes	2 <b>∑</b> No	Specify:				Specify: W	hite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28e-1 show ont, the Medical Examiner runk be motified at	ted	15. Decedent's Ed			16a. Deced	ent's Usua	l Occupa	ition			16b. Kir	nd of Busines	s/Industry	
2	thin 7	Completed	(Specify only highest grad	College (1-40	r 5+)	life. L	OO NOT us	nk done d se retired,	uring mosi	t of worki	ng				
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and I	be fill Hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold of hold o	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		Sumame)		
3	J Mer J Mer narke	P	Vasyl Opa			N				Mari					
Maryland	d2 sh th and 7 is n traun		19a. Informant's Name/Relationship (7								il Route Numbe	er, City or	Town, State,	Zip Code)	21771
o)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Exprimer real by nutified at ange.		Daria N. King - D.  20a. Method of Disposition	aughter	20b. I	26421 Place of Dispos	sition (Nam	ne of		1 Ro	ad, Mo	unt .	Airy,	Marylar	nd
Baltimore,	ages int of t: If It y or o		1 ⊠ Burial 2 □ Cremation 3 □			cemetery, crem • John 1							1		
	ertme ortan injur		4 □ Donation 5 □ Other (Specify 21. Signature of Fundral Service License		-				1	reb.	6, 200	4 NC	rthamp	oton, P	enna.
Ba	Dep Dep		1	1.01.		0]	lin L	. Mo	leswo	rth	P.A., I	uner	al Hon	ne	
1			23a. Pert1. Exter the disease, or comp shock, or heart failure. List only of	lications that caus	ed the dear	th. Do not enle	r the mod	e of dying	e Koa , such as	cardiac o	Damascu or respiratory ar	rest,	larylar	d 208	ate
H	Physician		Immediate Cause (Final disease or condition	ille Cause Oil each		< 910	-	60			200013	Δ.		Interval Be Onset and	
	/Medical		resulting in death)	a Due to (or a			-44-61		7	065	62 6200 K	200			
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	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consec	quence of):									
	and and trans	kam	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a											
8760,	icate be executed physician and s the burial-transit			D04 10 (01 a	2 at CO11284	(uarice oi).									
687	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai		d											
ŏ	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregna	ancy						1 2	3d. Date of de	discone	
m	death a atte d for	Iciai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant			Ectopic pre Other (spe					-	Month	Day	Year
0	that the de led by the a detached	hys	9 Unknown	9□ Unknown								1			
S,	igned be del	by P	Part II. Other significant conditions co	ntributing to death	but not res	sulting in the un	derlying ca	iuse give	n in Part I.		23e. Did to	bacco us	e contribute	to the cause of	death?
ğ	w require	ed									1 □ Y	es 2 🔀	3 □ F	robably 4 [	]Unknown
Vital Records,	has be	Completed									24a. Was a		24b. Were a	utopsy findings completion of	available
		Con							_		perfor	med?	death?	San.	Cause of
ıta	Physician: Th rthis certificate ral director, pag	Be (	25. Was case referred to medical examiner?							of Death	(Check only or				
0	Physi this c ral dire	2	1 185 2 100	-lospital: 1 ☐ Inpai		ER/Outpatient			4 (20) 1901	sing Hon	ne 5 🗆 Resid	ence 6	Other (Spe	ecify)	
ב	After une	io :	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D	ury ay Year)	28b. Time of Injury		Bc. Injury Work			8d. Describe h	ow injury	occurred		
<u>s</u>	eath or:	icat	2 Accident Investigation 3 Suicide 6 Could not be	20a Plana of In	ium. At h	ome form also	M		es 2 N		104 Landing (C	4	A/	10	
Division	or Attend after death Director: A in by the f	Certification:	4 Homicide determined	28e. Place of Ir building, e	itc. (Specif	bine, rarm, stre	et, ractory,	опісе		-	8f. Location (S City or Tow	n, State)	Number of H	urai Houte Nur	nber,
_	To the Hospitel or Att within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier 1 Certifying Phy	sician: To the bes	t of my kno	owledge, death	occurred a	it the time	e, date and	place a	nd due to the c	ause/e) a	ind manner a	s stated	
	ne Ho ne Fu netely	edical	(Check only 2 Medical Exami	ner: On the basis and manner s	or examina	ation and/or inve	estigation,	in my opi	nion, death	occurre	d at the time, d	ate and p	place, and du	e to the cause(	s)
	To the within To the Comp	Me	29b. Signature and title of dertifier	1		1	29c.	License	number		2	9d. Date	signed (Mon	th, Day, Year)	
•			) \ Au	Uill	1	/		40	051	200	0	Febr	uary 2	. 2004	
			30. Name and address of person who co	ompleted cause of	death (Iten	n 23a) (Type, P				_				2087	4
_			Anushiravan Dad	gar M.D.	132	219 Exe	cutiv	e Pa	rk Te	erra	ce, Ger	manto	own. M.		
	Sta Registra		FEB 0 3 2		rar's Signa		Sand !								

			1 - For State Registrar	State of Man	land / Depa <i>Cea</i>	artment of H	lealth and N Death	lental Hyg	giene 2 (	04	05273
	Dhunia		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath		3. Time of Death
	Physic /Medi		William Geo	rge Howar	d, Sr.			Februa	Day rv 1. 26	Yeer 004	9:00 A M
1	Examir		4e. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County		7,00 1
			8483 Inspirațio				rsville		Fre	ederi	ck
v	Funeral		Social Security Number     6. S     1	ETM 2DE	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h v. Year)		lece (Stete or Foreign
	Director		578-28-4152 Usuel Residence of Decedent	89	Yrs.			July 9	, 1914	Vir	ginia
	land Mo		10a. State 10b. County	10	c. City, Town or Lo	cation				10	Od. Inside City Limits
	Many -1 sh	to	Maryland Frederi	ck	Walkers	wille					1 ☐ Yes 2 ☑ No
	the	Director	10e. Street and Number		Walkele	10f. Zip Code			10g. Citizen of V	What Coun	trv?
	h with		8483 Inspiration	Avenue		2179	33		United		
	deat	Funeral	11. Marital Status	12. Was Decedent Eve		Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-		e - America	
Maryland 21215-0036	d within 72 hours after death with the Maryland Jione. rithan "natural", or Items 23a or 28a-f show tra Modical Examinar must be notitied at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces?  1 X Yes 2 □ No If Yes, Give Year or Dates: W		f Yes, specify Cuba 1 □ Yes 2💢 No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify	ck, White, e	etc. hite
Š	2 hou		15. Decedent's Ed	ucation	16a. Deced	ient's Usual Occupa	ation		16b. Kind of Bu		
215	within 7. ene. than "n	Completed	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	furing most of work	ing	TOD. TRITO OF DO	1311103321110	ustry
21	d with giene.	mo.	12	College (11401 54)	Build	ing Engir	neer		Suburba	an Ho	spital
g	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	First, Middle,			*
<u>a</u>	should be nd Mental marked o	70	Bert Howard				Helen	Fox			
an	2 sho and !	Ċ	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Street a	nd Number or Rura	A Route Number	r, City or Town,	State, Zip	Code)
	Daff 22		Karen L. Smock,	daughter	8894	Successf	ul Way	Walkersv	ville, M	íD 2	1793
ore	of Hea of Hea fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 XXX remation 3 ☐		Ob. Place of Dispo. cemetery, cren	sition (Name of natory or other place	9)	Date	20c. Location -	City or Tov	vn, State
Ĕ	Pages ment of I ant: If it ury or o		`4 □Donation 5 □ Other (Specify		Frederick	Cremator	y 2/3/	04	Frederi	ck. N	Maryland
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Lion	- Saure	-0 16	Name and Addres	s of Facility Star	uffer Fu	uneral H	lomes	, P.A. Land 21702
100	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1		23a. Part1. Enter the disease or composhock, or heart failure. List only	lications that caused the	death. Do not ente	er the mode of dying	, such as cardiac o	or respiratory arr	est,		Approximate
	Physician		Immediate Cause (Final	metast	ic P	rostoje	Can	105			Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a co			C-0071				4-11-
	Examiner		Sequentially list conditions.	b							
	p ti	Examiner	Sequentially list conditions, if any hand in terminal cause. Enter Underlying Cause (Disease or injury	Due to (or as a no	ntiecuanoa of):						
	and trans	cam	that initiated events resulting in death) Last	c							
60,	oe ex		rooding in ooding cast	Due to (or as a co	nsequence of):						
68760,	icate be executed physician and s the burial-transit	edlcal		d							
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Вох	at the death certifi I by the attending stached for use as	Physiclan/M	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	Ectopic pregnancy			23d. Date Mon	of delivery	y Day Year
<u>о</u> .	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ordeath 5	Other (specify)					
	res that I		Part II. Other significant conditions co	ntributing to death but no	t resulting in the un	deriving cause giver	n in Part I	23e Did tob	nacco use contri	huta to tha	cause of death?
Records,	The law requires that the death certi tle has been signed by the attending tage 2 should be detached for use a	Completed by								3 🗌 Probat	
ec	e law i has b	ble						24a. Was ar autops	n 24b. W	ere autops	sy findings available pletion of cause of
<u> </u>		Con						perforn	nea de	eath?	
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Death				
<u></u>	Physic this c at dire	2	1 ☐ Yes 2 ☐ No	fospital: 1   Inpatient	2 ER/Outpatient	3□ DOA Other	4 Nursing Hon	ne 5 eside	ence 6 Other	r (Specify)	
ū	Attending Physician: r death. sctor: After this certifici by the funeral director.	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe ho	w injury occurre	d	
sio	tend leath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be				es 2 No				
Division of	or At ifter of Direct in by	ertiflcation:	4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, stre	et, factory, office	2	8f. Location (Str. City or Town	reet and Number n, State)	r or Rural F	Route Number,
	pital urs a eral [	O	000 000	1							
	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best of my ner: On the basis of examination and manner stated.	knowledge, death mination and/or invi	occurred at the time estigation, in my opi	e, date and place, a nion, death occurre	nd due to the ca d at the time, da	tuse(s) and man ate and place, ar	ner as state ad due to th	ed. ne cause(s)
	with To I	Σ	29b. Signature and title of certifler	11 1	11)	29c. License	number	29	9d. Date signed	(Month, Da	ny, Year)
7				Hub, M		D 4	18184		2121	0 6	+
	6		30. Name and address of person who co	7	(Item 23a) (Type, P	rint)	Th at	+ 5	1		ole .
	2 series		Elhamy Esko		56	1 W /	STree	1 tred	lerick p	11) 2	21701
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S	agnature	1 .					
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AMENDED Item #4 State of Maryland / Department of Health and Mental Hygiene 1 - State WCHD/SH 2/5/04 per FH Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** PM /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number Examiner lash INGton WOOD 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Year) Hours 1 M 2 □ F 9 Yrs. 1906 Director JERMANY Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue 21795 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Importent: If item 27 Is marked other the any injury or other traumers. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No white Specify: tf Yes, Give Year or Dates: Specify: ð 3 ⊠ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 butcher supermarket 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johan Hauser Philippine Seifert ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Walsh - daughter 17103 Bakersville Rd., Boonsboro, Md. 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Hagerstown Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 2/7/04 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME Call E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1100, Physician 679/5TV2 /Medical Due to (or as a consequence of) Examiner hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit 01216 that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 5/01 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 Other (specify) the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ þ 1 Tes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hast autopsy performed? page this certificate 1□ Yes 2□ No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Diractor: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 - Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00056413 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WilliamSpeat XENG 3 6 a 31. Date filed (Month Paid Yea () State 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of M	Maryland	l / Depa <i>Cei</i>	artmen	t of H e of L	ealth a Death	and M	lental Hy	/gien	200	L.	05275
	Discosioni		1. Decedent's Name (First, Middle, Las	t)							2. Date of D	eath			3. Time of Death
	Physici /Medi		Dorothy Mae HOFFM	IAN							Feb.	4	y Ye; 2004	ar	1104 AM
	Examir		4a. Facility Name (If not institution, give	street and numbe	or)		4b. City,	Town, or	Location of	of Death	-		. County of D	eath	- 1
1			10315 Sharpsburg	Pike			Hag	erst	own			IV.	ashing	ton	
	Funeral		Social Security Number     6. Security Number	9x 7.7	Age (In yrs. la		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth	9 1		ce (State or Foreign
	Director		212-30-9377		81	Yrs.	W.O.M.	Juju	110010		May 13			nns	ylvania
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation							100	
	show	5			100. 01.,									100	I. Inside City Limits  1 ☐ Yes 2 No
	the N	Director	Maryland Washing  10e. Street and Number	ton		Над	ersto								
	with a	古					10f. Zip					-	tizen of What	Country	y?
	s 23	Funeral	10315 Sharpsburg	Pike 12. Was Deceder		140.1			1740				.S.A.		
	item item	Ş	11. Marital Status  1 □ Never Married 2 🖾 Married	Armed Forces	s?	. 13. 1	Yes, spec	ent of His	spanic Ori n, Mexican	gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)	o-	14. Race - Al Black, W		
38	irs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			I□ Yes 2	<b>□</b> No	Specify:				Specify:	T 71* .	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show ha Medical Examiner must be inclifted at	P	15. Decedent's Edi	ucation		16a. Deced	lent's Usua	l Occupa	tion			16b K	ind of Busine	Whi	
75	7 nic 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)			(Give life. L	kind of wor OO NOT us	k done d e retired)	uring most	of workir	ng	100.11	and or Dusino.	3311100	Suy
212	d with	E	12	College (1-40	(3+)	home	maker	r				he	r own	home	9
Þ	e file of he vent,	Be C	17. Father's Name (First, Middle, Last)		,				18. Mothe	r's Name	(First, Middle	, Maider	Sumame)		
<u>a</u>	uld by Aenta rked tic e	TOE	Homer L. Davis						E	mma	Orzel				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at	,-	19a. Informant's Name/Relationship (T)	ype, Print)		19b. Mailin	g Address	(Street a	nd Numbe	r or Rura	Route Numb	er, City	or Town, State	, Zip C	ode)
	alth alth 27 i		Merle C. Hoffman	- husbar	nd	1031	.5 Sha	arpsl	ourg	Pike	, Hage	rsto	wn, Md	. 21	1740
Baltimore,	permit. Pages 1 an Department of Heal important: if item 2 any injury or other once.		20a. Method of Disposition	2		ce of Dispos	sition (Nam	e of her place	)	D	ate	20c. L	cation - City	or Towr	, State
Ĕ	Page nent ant: I		1 ☑ Burial 2 ☐ Cremation 3 ☐ P  '4 ☐ Donation 5 ☐ Other (Specify)		9	r Lawı	-			2/9/0	)4	На	persto	wn .	Maryland
alti	partr ports y inju		21. Signature of Funeral Service Licens	see	_ /	22	Name and	Address	of Facility	Mi	nnich	Fune	ral Ho	me	naryrana
8	Depa impo any i		Scatto	Willen	usa								n, Md.		740
			23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o	lications that cause	ed the death.									A	pproximate terval Between
	Pinysician		Immediate Cause (Final disease or condition		0	. As	1								nset and Death
1	/Medical		resulting in death)	a Due to (or a	s a conseque	nce of):	Ch	-ce						+	1 year
	Examiner		Sequentially list conditions	h											
	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or injury	Due to (or a	s a conseque	nce of):									
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ő,	death certificate be executed e attending physician end id for use as the burial-transit	ŭ	resulting in death) Last	Due to (or a	s a consequer	nce of):									
8760,	ate b hysic the b	dical		d										-	
9	ath certific ttending p or use as	Me	IF FEMALE:											-	
Вох	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcom: 1 ☐Live birth	2 Fetal de	eath 3 🗆	Ectopic pre					1	23d. Date of d Month	elivery Da	y Year
		/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant a 9□ Unknown	at time of deat	th 5 ☐	Other (spe	cify)					MOHIT	Ua	y real
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Division of Vital Records,	signe Signe	ρ	atti. Other significant contations co	inibuting to death	DULTION 1950IR	ng in me un	derlying cal	use giver	ıın Parti.						ause of death?
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=	cate ha	S.										rmed? 2⊟1√o	death? 1 ☐ Ye		] No
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ot	Phys this ai dir	2	1 Yes 2 No	1 L Inpat	ient 2 ER			Other	4 □ Nur				G □Other (Sp	ecify)	
L C	After funer	<u>6</u>	1 ØNatural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Yeer)	Bb. Time of Injury		c. Injury a Work?			d. Describe h	iow injur	occurred		
isi	Attending r death. ector: After by the fune	Cat	2 Accident investigation 3 Suicide 6 Could not be	On Plan of In	iva. At home		M		es 2⊡N		M. I				
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	To the To the Comple	Me	29b. Signature and title of certifier	and manner of			29c.	License (	number			29d. Date	signed (Mon	th, Dev	Year)
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	7	}	30. Name and address of person who co	moteted course of	doub (ltam of			V	116	6 (			<u> </u>	0	7
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	Registra		10002	(11)4 Pan	Error 1	4. 1.	- 11								

			1 - For State Registrar	State of Marylan	d / Depa		Health ar	nd Mental Hyg	iene •g. No. 200	4 052 <b>76</b>
	Physici	an	1. Decedent's Name (First, Middle, Last)  MAMTE IONA I	UTZELL		-		2. Date of Dea	Day Yee	
	/Medic		4a. Fecility Name (If not institution, give s			4b. City, Town,			4c. County of De	eeth
			WASHINGTON COUNTY		In a 4 h Sath ata		HAGERS'			SHINGTON
۲.	Funeral Director		5. Social Security Number 220-80-7051 6. Sex	7. Age (in yrs. 84		Months Days		Min. 8. Date of Birth (Month, Day)	, 1919	Sirthplace (State or Foreign Country) MARYLAND
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Maryla a-f eho	to	MARYLAND WASHI	NGTON		I	HAGERST	OWN		1∑Yes 2□No
	vith the	Director	10e. Street and Number			10f. Zip Code	21740		0g. Citizen of What	Country?
	ns 23e	Funeral	750 DUAL HIGHWAY	2. Was Decedent Ever in U	.S. 13.	Was Decedent of		n? (Specify Yes or No- Puerto Rican, etc.)		nerican Indian,
920	within 72 hours atter death with the Maryland ene. then *naturel', or items 23e or 28e-f ehow he Mudical Ezaini et innel te notified at	Ď.	1 Never Married 2 Marned  Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specify Cul		Puerto Rican, etc.)	Black, Wi	hite, etc. WHITE
5-0	72 hours naturel',	eted	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occu kind of work done DO NOT use retin	during most o	of working	16b. Kind of Busines	ss/Industry
21215-0036	filed within 72 ho Hygiene. ther then "natur int, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	HOMEM			OWN	HOME
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Mai	d 2 T le		19a. Informant's Name/Relationship (Type RICHARD E. HUTZELI					ROAD, WAYNE		
ore,	es 1 an of Heal of Heal of Hem 2		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re	20b. F	Place of Disponentery, cre	osition (Name of matory or other pla	ace)		20c. Location - City	
Baltimore,	nit. Pages artment of ortant: If It injury or o		* 4 □Donation ) 5 □ Other (Specify)	BOO		CEMETER				, MARYLAND
Ball	permit. Par Department Important: eny injury once.		21. Signature of June al Servic L	7	E	2. Name and Addr BAST FUNE	RAL HO	ME BOONSBO	D NATIONA RO, MARYL	AND 21713
ŧ	Physician		23a. Plant . Enter the disease, or compite shock, or heart failure. List only on Immediate Cause (Final	eations that caused the deat e cause on each line.	th. Do not en	ter the mode of dy	ing, such as ca	ardiac or respiratory arm	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	uence of):	1-01	Pall.	1 .		
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.O. Box	ne death cer the attendir hed for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Sc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Il death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date of o	delivery Day Year
Ω.	juires that the signed by ald be detacted	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the	enderlying cause g	iven in Part I.	•	bacco use contribute	to the cause of death? Probably 4 Onknown
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Vital	ysician: is certific director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	El-VOutpatie	nt 3 DOA	thac	of Death (Check only on sing Home 5 Reside		necify)
ion of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju		28d. Describe ho	ow injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special		reet, factory, office	•	28f. Location (Si City or Town	reet and Number or n, State)	Rural Route Number,
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	To the within To the comple	Me	29b. Signature and title of certifier			_	nse number	2	9d. Date signed (Mo	
	(		1	2 1	m.1	2. 0	0041	131	Feb.	
4	- Y		30. Name and, ddress of person who co	UPPECES,	M.D	Print) 25	1 Eas	town;	onp 12	1740
	Sta Regist	ate rar	31. Date filed (Month FEB 1997) 20	32. Profistrar's Signa	A. A.	perte	′	(		

State of Maryland / Department of Health and Mental Hygiene 2004

05277 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** Raymond Lee Hovermale 11:40am Feb.6,2004 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Hagerstown, Washington Julia Manor Nursing Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Apr. 9, 1939 Birthplace (Stete or Foreign Country)
 WV Funeral Months Days 1 □ M 2 □ F 236-58-3222 64 Yrs. Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours aftar death with tha Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD Washington Clear Spring, 1 ☐ Yes 2 No **Funeral Director** 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 12102 National Pike 21722 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 O F Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Status XYes 2□No 1956 Yes, Give 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 white 1 ☐ Yes 2 ☐ Yeo Specify: δ f Yes, Give Year or Dates: 1962 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Truck MFG College (1-4or 5+) Elementary/Secondary (0-12) Machinest 12th grade Department of Health and Mental Hygi Important: If Item 27 Is marked other any Injury or other traumatic event, I 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell Lee Hovermale Rosie V. Duckwall 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)  $P.O.BOX\ 712\ Fort\ Ashby,\ WV\ 26719$ 19a. Informent's Name/Relationship (Type, Print) Richard Hovermale son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Cem. Feb. 10, 2004 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald Edwin Thompson Funeral Home Inc P.O.BOX 310 Clear Spring, MD 21722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical LUNG CANCE Examiner Examine Attending Physician: The law requires that the death certificate ba axecuted the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of): attending for use as signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3⊠ Probably 4 Unknown þ been si should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s cartificata has b director, paga 2 s 111765 24110 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 Yes 20 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funaral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred Affer 1 Natural 5 Pending filled in by tha fu investigetion 1 Yes 2 No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide To the Hospital or 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mile 00 01 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Khalid M.Waseem 1126 Opal Court Hagerstown, MD 21740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State The State of Registrar

				State of Marylan	d / Depa <i>Cei</i>	artment of tificate of	Health ar <i>Death</i>			e 20	04	0527	
H	Physici /Medic		Decedent's Name (First, Middle, Last)     Doris Winona					2. Date of Month	ary		664	3. Time of Death 8:20P	
	Examin	er	4e. Facility Name (If not institution, give st. 3173 Vista Court	reet and number)								of Death Carroll	
S.c.	Funeral Director		5. Social Security Number 218-18-2392 6. Sex	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Sept	of Birth Day, Yea	1923	Mary	ace (State or Fore	sign
	Ba-f show	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland Carroll		y, Town or Lo	New W	indsor					d. Inside City Lim	
	h with th	al Dire	10e. Street and Number 3173 Vista Court			10f. Zip Code	21776		10g. C	Citizen of Wh		<b>y</b> ?	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28e-f show any injury or other traumatic event, the Madical Examination in annease.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  *S Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	'	Was Decedent of f Yes, specify Cul 1 ☐ Yes 2 ☐ No		n? (Specify Yes o Puerto Rican, etc	or No-	14. Race - Black, Specify:	White, e		
Maryland 21215-0036	d within 72 ho giene. r than "netur Ine Medical	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire feteria	during most o		16b.	Kind of Busi			
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3760,	Physician //Medical Examiner	lical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or as a consequence to (or a))).	uence of):		ELB1			Cell		Approximate nterval Between Driset and Death (O MO)	
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(	6		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type, 122 Sl	Print) ude Av	cnue	Suite	101 Bal	timoi	1208 c 140
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's							

State of Maryland / Department of Health and Mental Hygiene - State Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 4, 2004 **Physician** CARLOTTA RANDOLPH HANSON 12:58 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGE'S CLINION

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | (Month, Day, Year)

AUG 27, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F MAINE 006-14-3323 1922 Director Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits ral', or itema 23a or 28a-f ahov Examiner must be notified at 1 ☐ Yes 2 XNo Directo MARYLAND PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12200 FENNO ROAD 20772 UNITED STATES Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced "natural", WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than Elementary/Secondary (0-12) College (1-4or 5+) 12 NURSE HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CARL EMMANUEL RANDOLPH ANNA BRITA NORBECK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEONARD F. HANSON - HUSBAND 12200 FENNO ROAD, UPPER MARLBORO, MD 20772 20a. Method of Disposition
1923 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State FEBRUARY Pages nent of h \* 4 □ Donation 5 □ Other (Specify) BROOKFIELD CHURCH CEM 9, 2004 NAYLOR, MARYLAND MGBnature of Funeral Service Licensee 22. Name and Address of Facility M00053 but 4 ( Surhaum HUNTT FUNERAL HOME P.O.BOX 156, WALDORF, MARYLAND 20004 Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** infarctin MyocAnnial /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, is amy go immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Dua to (or as a surisequence of) attending physicien and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) Ö à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c Certification: To 1 ☐ Yes 2 📉 No of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 29c. License number Wellin I. Varrer us 335206 February 4, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Illiam T. TANNOR AM 11201 Livingston Road Ft. WASHington, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 0 State Registrar

		1 - For State Registrar	State o	f Marylan	id / Depa <i>Cei</i>	artmei rtifica	nt of He te of E	ealth a Death	and M		Reg. No		) 4	0528
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The law requires that the death certificat. The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	utcome of pregni birth 2   Feta nant at time of conown	al death 3	⊒Ectopic ⊒ Other (	pregnancy specify)					23d. Date of Month	-	ry Day Year
s that I	by Ph	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	inderlying	cause give	n in Part	I.	23e. Dio	tobacco	use contribu	ute to th	e cause of death?
w require been sig should b										1	] Yes 2	2 □ No 3	☐ Proba	abiy 4 ⊠Unknown
al necon n: The law re ficate has be rr, page 2 sho	Completed				· · · · · · · · · · · · · · · · · · ·					24a. We aut per 1 Yes	opsy formed?	24b. We prided	re autop or to con oth? Yes	osy findings available apletion of cause of
Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	200		h (Check onl)	-			
Phys	To To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	of Injury	ER/Outpatie		28c. Injury Work	4   N		me 5 ☐ Re 28d. Describ				)
Attending r death. ector: After by the fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		nth, Day Year)	Injury	М		<br Yes 2 □	]No					
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2:	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	4   289. Flac	e of Injury - At h ding, etc. (Speci	nome, farm, st	reet, facto	ory, office			28f. Location City or 7	(Street a	and Number te)	or Rura	Route Number,
To the Hospital or within 24 hours after To the Funeral Direction completely filled in	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	miner: On the											
To ti To ti comp	×	29b. Signature and title of certifier		_		2	9c. License	number	-		29d. D	ate signed (	Month, I	Day, Year)
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(4)		30. Name and address of person who					ni+-	. <b>1</b> . D.	ri	Oh -	***	1		20785
S	tate	31. Date filed (Month, Day, Year)	₽.	Registrar's Sign	ature	مر مر	PICO	<u> </u>	TIVE	L CITE	ver	<u> </u>	ıa	20785

State of Maryland / Department of Health and Mental Hygiene 2004 05282 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Farnsworth Hester, Jr. 7:21 PM JANUARY 2004 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral 1√2 M 2□ F 577-90-5440 40 Director Nov 1, 1963 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or iteme 23s or 28s-f show event, the Wedical Examinar must be notified at MD Prince George's Director 1 Yes 2 □ No Greenbelt 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9112 Edmonston Road #304 20770 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1X Never Married 2 Married 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 21215-0036 1 ☐ Yes 20XNo Specify: <u>ک</u> Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 3 yrs Barber Self Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental Farnsworth Hester, Sr. traumatic Patricia Cash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health ? 9112 Edmonston Road #304; Greenbelt, MD Patricia A. Hester - Mother 20770 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Department of Important: If any injury or once. Glenwood Cemetery 2/3/2004 4 ☐ Donation 5 ☐ Other (Specify) Washington, D.C. 22. Name and Address of FacilityRobert O. Freeman Funeral Svcs 21. Signature of Funeral Service Licensee XXe endour ena 1353 H Street, N. E. Washington, D.C. 23a. Part1 Effer the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Myocardial infarction 12/03 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed Pneumonia 12/03 burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Diabetes type II Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year signed by the air d be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? Yes Ala No has certificate 1 Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes XX No 2X ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t or Attending 1 Natural 2 ☐ Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No hours after death. investigation the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) the th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19446 January 28, 2004 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 575 MAIN STREET SUITE 351 LAUREL, MD 20709 3/EVEN 5. KEMSEN 31. Date filed (Month, Day, Year)
FEB 0 4 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05283 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death George Parker Harned III January 31, 2004 7:15 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Hours Months 1 ☑ M 2 ☐ F 47 214-66-3904 Sept. 8, 1956 Virginia Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4800 Naples Avenue 20705 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Parker Harned II Audrey Ray Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark R. Harned Brother 446 Elmhurst Street, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2/4/2004 Alexandria, Virginia 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Daltimore Ave., Hyattsville, MD 20781 1ac 23a. P. nt. Enter the disease, or complications in the used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, how, or heart failure. List only one gause on each ine. Immediate Cause (Final disease or condition Mepatic Encephalopathy resulting in death) Due to (or as a consequence of): Alcoholic Liver Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Thrombocytopenia 1 Yes 2 No 3 Probably 4 ∑Unknown 24b. Were autopsy findings available prior to completion of cause of death? Normocytic Normochromic Anemia 24a. Was an autopsy 1 Yes 2 No Azotemia 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinat: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D10660 February 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician /Medical Examiner attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, signed by i has e 2 s page certificate To the Hospital or Attending Physician: Director: After that in by the funeral

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ir than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at

Funeral Director

à

Completed

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Examiner

Physician/Medical

by

Completed

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death with the Maryland

filed within 72 hours after

Hygiene.

Baltimore, Maryland 21215-0036

Certification: within 24 hours a Medical

Registrar

R. Weber, MD

FEB 0 5 2004

32. Registrar's Signature

1838 Greene Tree Road, Suite 500, Baltimore, Maryland 21208

State of Maryland / Department of Health and Mental Hygiene 2004 0528L

		Certificate of Death		Reg. No.	0528				
hysician	Decedent's Name (First, Middle, Last)		2. Dete of De Month		3. Time of Death				
Medical	JOSEPHINE HEDGER  4a Fecility Name (If not institution, give street end number)	4b. City. Town.	or Location of Beath		11:30PM				
aminer									
ral	5. Salisbury Nursing and Rehab Cen	st birthdey) If Under 1 Year Whole 24 Months Deys Hours N	2. Dete of Deeth Month Dey Year 3. Time Month Dey Year 3. Time April 7, 1902 Wicomico New Yor.  1. Or Location of Death Ac. County of Death Min. (Month, Dey, Year) Paril 7, 1902 New Yor.  10d. Inside 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	place (Stete or Fore					
tor	126-32-2501 1DM <b>X</b> DF 101	Yrs. Working Days Hours N	April 7						
	Usuel Residence of Decedent     10a. Stete   10b. County   10c. City.	Town or Location			104 1				
ច					l0d. Inside City Lir 1 X Yes 2 □				
Director	Maryland Wicomico Sa.  10e. Street end Number	lisbury 101. Zip Code		10-07					
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era	11. Maritel Status 12. Was Decedent Ever in U,S	. 13. Was Decedent of Hispenic Origin?	(Specify Ves or No.		an Indian				
Completed by Funeral	1 Never Married 2 Merried Armed Forces?  1 Yes 2 No	If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White,	etc.				
d b	3 ☐ Widowed 4 ☐ Divorced Year or Detes:	TE 165 BE 160 Specify.		Specify: W	111 00				
ete	15. Decadent's Education (Specify only highest grede completed)	16e. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Business/Ind	dustry				
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To	19a. Informant's Name/Relationship (Type, Print)	Blanc			0.41				
To Be Completed by Funeral Director	John H. Hedger, MD/nephew				CO08)				
		ce of Disposition (Name of metery, crematory or other place)			wn State				
	Dunial 2 Commation 3 Chemoval from State								
	21 Signature of Funeral Service Licansee	odlawn Cemetery  22. Name and Address of Facility	1/30/04	Sandy Creek,	NY				
S	60 100	Holloway Funera	1 Home Pr	ofessional A	ssociat:				
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an al er o	Immediate Cause (Final disease or condition resulting in death)  a. p \ Circ	se e consequence of):			2 days				
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Be	25. Was case referred to medical examiner?	26. Plece of D	eath (Check only or	ne)					
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65	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At hombuilding, etc. (Specify)		28f. Location (S City or Town	itreet and Number or Rural n, State)	Route Number,				
Sertifica				ause/s) and manner as ets	hate				
edical Certification:	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowle and manner stated.	edge, death occurred at the time, date and pla n and/or investigation, in my opinion, death oc	ce, and due to the c curred at the time, d	late and place, and due to	the cause(s)				
Medical Certifica	(Check only 2   Medical Examiner: On the basis of examination	29c. License number	curred at the time, d	late and place, and due to	the cause(s)				
Medical Certifica	one)  2 Medical Examiner: On the basis of examination and manner stated.	n and/or investigation, in my opinion, death oc	curred at the time, d	late and place, and due to	the cause(s)				
edical	one)  2 Medical Examiner: On the basis of examination and manner stated.	29c. License number	curred at the time, d	late and place, and due to	the cause(s)				

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		1. Decedent's Name (First, Middle,	Last)								h Day	Year	3. Time of Death
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for use	ysician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐Live birth 4 ☐ Pregnan	2 ☐ Fet t at time of	aldeath 3							te of delive	ery Day Year
deta	P P	Part II, Other significant condition	s contributing to deat	h but not re	sulting in the t	underlying o	ause giv	en in Part I.	23	3e. Did tol	bacco use conf	tribute to th	ne cause of death?
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N	complete								_	autops perforr	med?	Were auto prior to cordeath?	psy findings available mpletion of cause of 2 No
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000	-	290. Signature and title of certifier	11/100						,	-	1/2//	A A	-wj. ( cai /
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		30. Name and address of person w	the completed cause	of death (Ite	om 23a) (Type	Print)	Cd.	his .	10 210	1			
		V JOHN IGUI	113641 /6			0(/ (	14/15/	NI MI	J -10C	7			
Si Regis	trar	31. Date filed (Month, Day, Year)		istrar's Sign	Jacure &	1	oak	2					

Madeline Hitchins

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day WILLIAM TMES FEBRUARY 3, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days **1** M 2 □ F Hours 60 Yrs. Aug. Director 212-40-0049 6, 1943 Md. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Iteme 23s or 28s-f show the Medical Examinar must be notified at M☐Yes 2 ☐ No Directo Prince George's Capitol Heights Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5905 Applegarth Place 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 De la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company de la Company 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: Black 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th Chauffeur Limousine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental F Herbert Imes Jannie Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) eges 1 and 2 st nt of Health and :: If item 27 Is n Tahirah Smith / Daughter 4701 Alabama Ave., S.E. Wash., DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Peges 1
Department of H
Important: If ites
any injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Cem. 2-11-04 Owing Mills, Md. 22. Name and Address of Facility Capitol Mortuary, Inc. 21. Signature of Funeral Service Licenseq olly 1425 Maryland Ave., NE Wash., DC 20002 23a. P. 11. Enter the disease, it is implications that cause if the death. District the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CHRONIC PULMONARY Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Yes 2 No 3 Probably 4 Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 ☐ Yes 2 No certificate Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation or Attending 1 Natural Injury death. 1 Tes 2 No 2 Accident the Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Hospitel within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cartifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 104 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) SCHWARTZ STEVEN PGHC HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 5 2004 Registrar

	1:	ne 7 &8 FCHD; 2/4/04 Certificate of Death		Reg. No.20	04 (	1528								
Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Day	Year	Time of Death								
/Medic Examin		Anne Gabriel Janney  4a Facility Name (If not institution, give street end number)  4b. City, Town, or Lo	Januar cation of Deet			2:30 P								
Funeral Director		Montgomery Village Health Care Center Montgomery S. Social Security Number $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	8. Date of Bir (Month, De		gomery  9. Birthplace Country)  Ore	(State or Foreig								
yland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	Apri1	17, 1928	10d. l	nside City Limits								
Ba-f.s	Director	Maryland Montgomery Germantown			1	☐Yes X☐No								
章 <b>2</b> 4	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of V	Vhat Country?									
eth v		18011 Chalet Drive 20874			S.A.									
	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2∑ No If Yes, Sive Year or Dates:  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I □ Yes 2∑ No Specify:	Rican, etc.)	Specify	e - American Ir k, White, etc. : Whit									
I within 72 hours affi iene. r than "natural", or fre Medical Exami	Completed by	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of works on the completed of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete	ng	16b. Kind of Bu	siness/Industr	у								
	Com	Elementary/Secondary (0-12) College (1-4or 5+) 2 years Homemaker		Own	Home									
三エラミ	Be (	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle	, Maiden Sumam	e)									
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~ 0 <u>0</u> 65		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rure	er, City or Town,	State, Zip Cod	<sup>(e)</sup> 20874									
Pages 1 end inent of Health int: If Item 27 inty or other tr		Oliver M. Janney - Son 19125 Highstream Drive Oliver M. Janney - Son 20b. Place of Disposition (Name of cemetery, cremation 3 Removal from State Constitution of Constitution (Sassibility Constitution)  10 Burial 2 Constitution 3 Removal from State Constitution (Sassibility Constitution)  10 Burial 2 Constitution (Sassibility Constitution)	Date	20c. Location -	City or Town,	State								
permit. Pages Depertment of I Important: If ite any injury or of		4 Docation 5 Other (Specify)  Metropolitan Crematorium Inc. 2/1/04 Alexandria, Va.  21. Signature of Furneral Service Licensee  Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0												
	$\dashv$	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of			App	roximate								
Physician Medicul Examiner	-	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Aspiration Pneumonia resulting in death)  Due to (or as a consequence of):				rval Between set and Death								
nsit	in in	Coronary Artery Disease			1									
es that the death certificete be executed igned by the attending physician and be detached for use es the burial-transit	edicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Cirrhosis of Liver  C.  Due to (or as a consequence of):												
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death e atte ed for	sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did	tobacco use con	tribute to the	cause of deat								
nat the rid by the detache	F Š	Diabetes Mellitus	1 🗆	`		4 □ Unkno								
aw requir Is been s 2 should	Completed by		24a. Was perfo	an autopsy rmed?	available	utopsy findings e prior to tion of cause 1?								
The late has page	5		101	res 2000	1 ☐ Yes	2 □ No								
tor,	Be	25. Was case referred to medical examiner? . 26. Place of Death	(Check only o	ne)										
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tending Physical death.  tor: After this centhe funeral director	cation	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	0(1,)	24	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number or Rural Route Number or Town, State)									
its of Attending Physics its after death.  **I Director: After this cerelled in by the funeral director.	Certification	2 Accident investigation   M   1 Yes 2 No   Suicide   Accident   Accident   M   No 2 No   No   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Acci	8f. Location (S City or Tov	Street and Numbern, State)	er or Rural Rou	ite Number,								
No spiral or Attending Physici no 4 hours after death.  No Funeral Director: After this concluded filled in by the funeral director.	edicai Certification	2 Accident investigation   M   1 Yes 2 No   Suicide   Accident   Accident   M   No 2 No   No   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Accident   Acci	City or Tov	vn, State)										
No Hospital or Attending Physin 124 hours after death.  Perneral Director: After this copletely filled in by the funeral direction.	ledical Certification	2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, earth occurred at the time, date and place, earth occurred and manner stated.	City or Tov	vn, State)	nner as stated. nd due to the o	cause(s)								
to the Hospital or Attending Physici within 24 hours after death.  To the Funeral Director: After this ce completely filled in by the funeral direct	Medical Certification	2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time, date and place, each occurred at the time,	City or Tov	on, State) cause(s) and mandate and place, a	nner as stated. nd due to the o	cause(s)								
to une mospital or Attending Physici within 24 hours after death.  To the Funeral Director: After this ce completely filled in by the funeral director.	Medical Certification	2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, earth occurred and manner stated.  29b. Signature and title of certifier 29c. License number	City or Tow	cause(s) and mardate and place, a	nner as stated. Ind due to the o	cause(s)								

State of Maryland / Department of Health and Mental Hygienes Reg. No. 2 0 0 4 1 - For State Registra 05288 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2004 Year **Physician** Feb. HAZEL LEE HICKMAN JUSTICE 3, 11:46AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5803 Steffee Drive Snow Hill, Worcester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. Director 218-20-9200 78 1925 Virginia Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show r then "naturel", or Items 23a or 28e-f show the Medical Examinations the codified of 1 Yes 2 □ No Director Worcester Snow Hill MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5803 Steffee Drive 21863 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. within 72 hours after 1 Yes 2 No If Yes, Give / Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Domestic Homemaker nd 2 should be filed lith and Mental Hygid 27 Is marked other r traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elwood Francis Hickman Elva Doris Pusey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
importent: If item 27 Is
eny injury or other trau Doloris J. Ward/ Daughter 5803 Steffee Drive, Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 2/4/2004 Downing's Cem. Oak Hall, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HOLLOWAY Melson Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) netestatic Corcinona Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit be executed Due to (or as a consequence of): Box 68760 hysician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 靣 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2 X No Division of Vital After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 😿 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification; Attending 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident al or Attend after death filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Eb. 5 0004 030690 1.0. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 145 E Carroll St., 50/3/07. MARTIN E Janes 32. Registrar's Signature 31. Date filed (Month Dex, Year) 6 2004 State Registrar

State of Maryland / Department of Health and Mental Hygiens

		Certificate of Death Reg. N	<b>20</b> 04 05289
	Dhysisian	Decedent's Name (First, Middle, Last)  2. Date of Deeth  Month  Decedent's Name (First, Middle, Last)	3. Time of Death
	Physician /Medical	Artelle Elizabeth Holmes Jones January 20	5:20 A.M.
	Examiner	4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c 4c 4c 4c 4c 4c	c. County of Deeth  Montgomery
ali.	Funeral Director	5. Social Security Number 5.77-32-2030  6. Sex 1	9. Birthplace (State or Foreign
	and **	Usuel Residence of Decedent  10e. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	or 28a-f ehow be notified at Director	Maryland Montgomery Chevy Chase	Yas 2 □ No
	ifter deeth with the Mar r frems 23a or 28a-f ei niner must be notitied Funeral Director	10e. Street end Number 8700 Jones Mill Road   10f. Zip Code   10g. Ci     Manor Care Health Services   20815   Ur	itizen of What Country? nited States
9800	72 hours after deeth with the Maryland natural, or items 23s or 25s-f show dical Examiner must be notified at steed by Funeral Director		14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036	ied within 72 hours sygiene.  The Medical Exer.  Completed by	15. Decedent's Education (Specify only highest grede completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	Kind of Business/Industry
2	e filed with el Hygiene other than vent, tre.	9th grade Nursing Assistant  17. Fether's Neme (First, Middle, Last)  18. Mother's Name (First, Middle, Maide)	Hospitals
Maryland	Mentei H Mentei H mrked ott attc ever		i Sumame)
Z	2 should be and Mente is marked aumatic ev	19a. Informant's Name/Relationship ( <i>Type</i> , <i>Print</i> )  19b. Mailing Address ( <i>Street and Number or Rurel Route Number, City</i>	or Town, State, Zip Code)
Baltimore, Ma	ges 1 end it of Heaith if item 27 or other tr	Ransom Solomon Holmes (Nephew) 9727 Mt. Pisgah Road, Apt. 705; Silv 20a. Method of Disposition 1  Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 27, 2004	ver Spring, Maryland ocation - City or Town, State
#	Depertment Depertment Important: any Injury		ington, Virginia
Ba	Demi Depe Impo	R. N. Horton Company Mortici 600 Kennedy Street, N.W.; Wash	
	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximete Interval Between Onset and Death
	/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)  Cardiopulmonary Failure  Due to (or as a consequence of):	Immediate
	je e	Advance Dementia	
oʻ	ficate be axecuted physician and sthe burial-transit edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury	
x 68760,	E 20 5	that initiated events resulting in death) Last  Due to (or as a consequence of):  Malnourishment	
Box	daath cel e attendir ed for use sician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco	o use contribute to the cause of death
P.0	ras that the daisigned by the a lbe detached to be detached by Physic	1 Yes	_
of Vital Records,	aw requi	24a. Was en euto performed?	ppsy 24b. Were autopsy findings available prior to completion of cause of deeth?
E E	The iseta has paga	1 □ Yes 2	X No 1 □ Yes 2 □ No
/ita	star star star star star star star star	25. Was case referred to medicel examiner?	
1	2 0 0	1 ☐ Yes 2 No	
ion	Afte fund	27. Manner of Death   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1 Accident   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury   28d. Describe how injury	ry occurred
Division	tal or Attending P rs after deeth. el Director: After t lad in by tha funer: Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street at City or Town, State	nd Number or Rural Route Number, e)
	To the Hospital or Attending Ph within 24 hours after deeth. To the Funerel Director: After thi complataly filled in by the funeral Medical Certification: 7	29a. Certifier (Check only one)  12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s only one)  13 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s only one)	
	withir To th comp		ate signed (Month, Day, Yeer) uary 20, 2004
7		30. Name end address of person who completed cause of death (Item 23e) (Type, Print)	20815
	(G)	Ishtiaq A. Malik, M.D.; 4615 North Park Avenue, Suite 309; Chevy	
	State Registrar	FEB 0.2 2004 Secure & Sparles	

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05290 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** 2208 M 050 RhIn 194 /Medical 4b. City-Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 0/47319 0616 VUIV H Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 8 12 1 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 ☐ M 2 💢 F 219-61-3137 68 1935 Director Sierra Leone Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director PRINCE GEORGE'S MD LAUREL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20708 SIERRA LEONE 8805 BRANSLEY COURT Funerai filed within 72 hours after death 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0020 1□Yes 2≹ No Specify: 2 3 ☑ Widowed 4 □ Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th PRIVATE HOUSEWIFE th and Mental Hygie 7 is marked other to 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be SAMUEL STEVENS HENRIETTA WILLIAMS 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8805 BRANSLEY COURT LAUREL, MARYLAND 20708 JOSELYN B. JENKINS/SON 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/16/04 FREETOWN SIERRA LEONE 4 ☐ Donation 5 ☐ Other (Specify) KISSY VILLAGE CEMETERY 22. Nama and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner for use es the burial-transit Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No signed b 2 24b. Were autopsy findings available prior to completion of cause of death? iis certificete hes been si I director, page 2 should I 24a. Was an autopsy performed? Be Completed 2 UNO 1 - Yas 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 12 Natural 5 Pending 1 Tes 2 No death. investigation i Director: A d in by the f 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 - Homicide ò To the Hospital of within 24 hours of To the Funeral C completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29d. Date signed (Month, Dey, Year) 29c. License numbe a 00 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4921061 10805

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

FEB 04

2004

2. Registrar's Signature

	•	For State Registrar			Cer	tificate of	Death	Mental Hyg	2 0 U Reg. No.	4 0529
Physiciar /Medica		1. Decedent's Name (First, Middle, La Ralph Johnson,	- /					2. Date of Dea Month	Day Yea	3. Time of Death 12:00А м
Examine		4a. Facility Name (If not institution, giv Suburban, Hospi		m <i>ber)</i>		4b. City, Town, o Bethe		ath	4c. County of De	
Funeral Director		3//-62-8/06	ex Mim 2□F	7. Age (In yrs. I 58	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		r, Year)	Birthplace (State or Foreign Country) mington, NC
f ehow	Jo.	Usual Residence of Decedent  10a. State Montgome	ry		r, Town or Lor ethesd					10d. Inside City Limits 1X Yes 2 □ No
	Director	10e. Street and Number 5721 Grosvenor La	ne			10f. Zip Code	20814	4	10g. Citizensof What	Country?
Exeminer mus	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Deci Armed Fo 1 12 Yes If Yes, Gir Year or D	2 □ No ve		Vas Decedent of H Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue Specify:	(Specify Yes or No- erio Rican, etc.)	14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. Black
is marked other than "natural, sumatic event, the Medical Exe	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		1-4or 5+)	(Give life. L	ent's Usual Occup kind of work done OO NOT use retired ial Poli	during most of w d)		16b. Kind of Busines	ss/Industry
- A	lo pe Co	17. Father's Name (First, Middle, Last Ralph Johnson						ame (First, Middle,		ective byes.
er trauma	1	19a. Informant's Name/Relationship ( Vincent Johnson			19b. Mailin 1512	g Address (Street Howard Re	and Number or F	Ru <i>ral Route Number</i> Wash., I	r, City or Town, State	, Zip Code)
ıry or oth		20a. Method of Disposition 1 ☐ Burial 2 ⚠ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Special	Removal from	State	ametery, crem	sition (Name of patory or other place Park Cre		Date 1/2004	20c. Location - City of Riverdale	
Important: If item 27 is marke any injury or other traumatic once.		21. Signatur o Funerat Service Licer	A	sun	4	719 Keni	nedy St.	uneral Se	sh., DC 2	0011
sician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate se (Final disease or condition		aused the death ich tine.	. Po not ente	er the mode of dyin	ng, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death 3 PAY 5.
the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to	(or as a consequi	i∈ R∈ eneapt):	NAL	DISEASI	E		MONTHS
iched for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1 Live b	tcome of pregnation to the come of pregnation to the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the community of the comm	death 3 -	Ectopic pregnancy Other (specify)	,	200000	23d. Date of d Month	lelivery Day Year
should be detac	ea by r.	Part II. Other significant conditions of			lting in the un	derlying cause giv	en in Part I.			to the cause of death?  Probably 4 □Unknown
irector, page 2 should	Completed	DIABETES	MEL	LITUS			<del></del>	24a. Was a autops perform	med? death	autopsy findings available of completion of cause of ?
al director	10 De	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Matural 5 Pending 2 Accident investigatio	28a. Date (Mon	npatient 2 0 for the state of Injury th, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun Worl	er: 4 Nursing		ne) ence 6 □Other (Sp ow injury occurred	pecify)
filled in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place buildi	of Injury - At ho ng, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (St City or Town	treet and Number or i n, State)	Rural Route Number,
	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exar	niner: On the b	best of my know asis of examinat ner stated.	vledge, death ion and/or inv	occurred at the tin estigation, in my of	ne, date and place pinion, death occ	ce, and due to the co curred at the time, d	ause(s) and manner ate and place, and di	as stated. ue to the cause(s)
	2	29b. Signature and title of certifier	, MO,			29c. License	e number		9d. Date signed (Mod	nth, Day, Year)
////	- 0	30. Name and address of person who	completed caus	e of death (Item	22a) /Tupo F	Beine)			77-11-20-11-20	

ral', or itams 23a or 28a-f shov Examinar must be notified at

"natural",

than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any injury or other traumeth.

Physician

The law requires that the death certificate be executed

Hospital or Attanding Physician:

the

after deat Director:

within 24 hours a To the Funeral C

Division of Vital Records, P.O. Box 68760,

/Medical Examiner

the attending physicien

jo

90

filed within 72 hours after

Baltimore, Maryland 21215-0036

Directo

Funeral

à

Completed

Be

2

Examiner

Physician/Medical

Completed by

Be

10

Certification:

Medical

Claudius Donnell Jefferson
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤦 05292 Reg. No. 2. Date of Death

Month

January

		1 - State Registrar			Certificat	e of i	Death			
		1. Decedent's Name (First, Mide	die, Last)							
	Physician /Medical	CLAUDIUS	ON JR.	JR.						
	Examiner	4a. Facility Name (If not institution Prince George				4b. City, Town, or Location of Cheverly				
	Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last bir			If Under	24		
	Director	212-25-6544	1 <b>∑</b> M 2 ☐ F	2.8	Yrs. Months	Days	Hours	1		
_		Usual Residence of Decedent								
ĕ	-	10. 0		140-00-7						

Prince George's 9. Birthplace (State or Foreign

12 19 A

10d. Inside City Limits

1 Yes 2 No

10a. State 10b. County

10c. City, Town or Location HYATTSVILLE 8. Date of Birth (Month, Day, 6 18 1975 MARYLAND

PRINCE GEORGE'S MD 10e. Street and Number 4603 BURLINGTON ROAD

10f. Zip Code 20747

10g. Citizen of What Country? U.S.A.

30, 2004

4c. County of Death

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give 1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

Year or Dates

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No Specify

14. Race - American Indian, Black, White, etc. BLACK

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 10th

LABORER

PRIVATE

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Sumame)

CLAUDIUS DONNELL JEFFERSON SR.

DESIREE FIELDS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type, Print) FATHER CLAUDIUS DONNELL JEFFERSON/

7703 GAMBIER DRIVE UPPER MARLBORO, MARYLAND Date

20772 20c. Location - City or Town, State

Interval Between Onset and Death

20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State ^ 4 □Donation 5 □ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) RESURRECTION CEME.

2-9-04

CLINTON, MARYLAND J. B. JENKINS FUNERAL HOME

21. Signature of Funeral Service Licensee

7474 LANDOVER ROAD LANDOVER, MARYLAND

23a. Part1. Enter the div ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final

Approximate

resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last

nultiple aunshot
Due to (or as a consequence of): multiple Due to (or as a consequence of):

Due to (or as a consequence of)

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4 Pregnant at time of death

3 ☐Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9☐ Unknown

Hospital: 1 ☐ Inpatient

23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 X No

3 Probably 4 Unknown

24a. Was an autopsy 1 Yes

2 No 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner? 1√2 Yes 2 No

27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

Date of Injury (Month, Day Year 5 Pending 29-04 investigation 6 Could not be determined

28e.

28b. Time of Injury 343 0 Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ☐ ER/Outpatient 3 ¥ DOA

Street

28c. Injury at Work?

28d. Describe how injury occurred

101 28f. Location (Street and Number of Rural Route Number, properties of State)

29a. Certifier (Check only one)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature, and title of certifie

29c. License numbe

29d. Date signed (Month, Day, Year) January 30, 2004

O.C.M.E.

30. Name and address of person who completed cause of (Item 23a) (Type, Print) woll1 Penn Street, Baltimore, Maryland 21201 ADI-

State Registrar

31. Date filed (Month, Day, Year) FEB 0 6 2004

			Cei	rtificate of L	Jeam		Reg. No.	2004	05293
1	. Decedent's Name (First, Middle, Las			-		2. Date of De Month	ath Day		3. Time of Death
	James Thomas Jor	dan Jr.							0633 P. <sup>M</sup>
						1		•	
						8 Date of Bir			
			Yrs.	Months Days	Hours Min.	(Month, Da 6/4/19	y, Year)	North	oface (State or Foreign ntry) Carolina
-		10	c. City, Town or Lo	ocation				1	I Od. Inside City Limits
		eorge's	Landove	er					Yes 2□No
5				10f. Zip Code			10g. Citi	izen of What Cour	ntry?
2	7212 Greeley Road			20785					
		Armed Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	)-		
2		If Yes, Give		1 ☐ Yes 2 <b>卷</b> No	Specify:			Specify: Bla	ick
ם ב	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation	kina	16b. Ki	ind of Business/In	dustry
ed -	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	i)	Kii i g			
5	12th		La	aborer	40 Markada Nas	a. /Fina Adiddle			
0							, waiden	Sumame)	
0			19h. Maili	na Address (Street :			er, City o	or Town, State, Zin	Code)
		* .							
1			20b. Place of Dispo	osition (Name of	re)	Date	20c. Lo	ocation - City or To	own, State
				matery of outer place		11/2004	Land	dover, M	D
	A. D. Hank	ell						MD 2078.	5
	Immediate Cause (Final disease or condition resulting in death)	a. Hypertens		liovascula	ar Diseas	se			Onset and Death
miner	Cause (Disease or injury	Due to (or as a co	insequence of).		-				
	resulting in death) Last	Due to (or as a co	onsequence of):						
Ved	15.555			-					-
ysician/n	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	1 Live birth 2 □	Fetal death 3					23d. Date of deliv Month	ery Day Year
7	Part II. Other significant conditions	contributing to death but n	ot resulting in the t	underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to t	he cause of death?
						1 🗆	Yes 2	□No 3□Pro	bably 4 Unknown
omplet						auto perfe	psy ormed?	prior to co death?	opsy findings available ompletion of cause of
e)	25. Was case referred to medical				26. Place of Dea				
0	1 Yes 2 No	Hospitaf: 1 Inpatient		HIL 3L DOA	4   Hursing r				fy)
tion:	1 Natural 5 Pending		ear) 28b. Time of finjury	of 28c, Injur Wor M 1	yat k? Yes 2 ∐No	28d. Describe	how infu	ry occurred	
ertifica	3 ☐ Suicide 6 ☐ Could not	208. Flace of injuly	- At home, farm, s Specify)	treet, factory, office					al Route Number,
		miner: On the basis of ex	amination and/or in						
ž	29b. Signature and title of certifier			29c. Licens	e number		29d. Da	te signed (Month,	Day, Year)
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State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

	_	Registrar			Cei	rtifica	te of D	eath		Reg. No	2004	
Physician		<ol> <li>Decedent's Name (First, Middle, Last Margaret L. Keyse</li> </ol>							2. Date of De Month Januar	Da	y Year 2004	3. Time of Death  11:40 A
/Medical Examiner		la. Facility Name (If not institution, give		iber)		4b. City	, Town, or L	ocation of Deat			County of Death	
Zammer		Northampton Manor	Health	Care	Center		Frede	ick			Freder	ick
Funeral Director	L		х ] м 2 <b>[х</b> ]	7. Age (In yrs 89	. last birthday) Yrs.			f Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da 10-21-	th 1912	9. Birth Con	place (State or Foreigntry) Maryland
<b>&gt;</b>	-	Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation					Т	10d. Inside City Limi
or 28a-1 show to notified at Director		Maryland Frederic	ck			rede	rick					1 XYes 2 □ N
r28a	-	10e. Street and Number			-		p Code			10g. Ci	tizen of What Cou	intry?
ai D	3	25 East Ninth St	reet				21701			Ur	ited Sta	ates
other traumatic event, the Madical Examiner must be notified at To Be Completed by Funeral Director	1	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed For 1  Yes If Yes, Give Year or Da	ceus? 2.⊠No 9		Was Dece 1 Yes, spe 1  Yes		anic Origin? (S Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	)-	14. Race - Amer Black, White Specify: V	
Completed by		15. Decedent's Edu	ication		16a. Deced	ient's Usu	ual Occupation	on	dei a a	16b. K	ind of Business/l	ndustry
n pie	-	(Specify only highest grad Elementary/Secondary (0-12)	College (1-	4or 5+)				ing most of wor	xing			
S P	5	11				Assei	mbly W				ir Pax	
Be S		17. Father's Name (First, Middle, Last)					18	3. Mother's Nar	ne (First, Middle	, Maider	Sumame)	
To To		George Beetz	una (Triat)		10h Mailte		- (011	Margar	et Dohe	rty	or Town, State, Zi	
7 Isr		19a. Informant's Name/Relationship (T) Le Roy Hansberger		*								p Code)
Important: It rein 27	- 2	20a. Method of Disposition		20b.	Place of Dispos	sition (Na	me of	ke, Ija	msville Date		21754 ocation - City or T	own, State
		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)			cemetery, cren rederic			V 2/2	/2004			Maryland
any injury or ODCO.		21. Signature of Funeral Service Licens						- , -, -			ral Home	
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detached for use as the Physician/Medi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		th 2 ☐ Fet int at time of	al death 3	Ectopic p Other (s)	oregnancy pecify)				23d. Date of deliv Month	ery Day Year
b ed yd	1	Part II. Other significant conditions con Hyperterns		ath but not re	sulting in the ur	nderlying (	cause given i	n Part I.		obacco (		the cause of death?
page 2 should									24a. Was	an	24b Ware auto	onsy findings available
age 2 s									autor perfo	rmed?	dasth?	opsy findings available impletion of cause of
Be Co	1 2	25. Was case referred to medical					2	S Place of Dea	1 ☐ Yes th (Check only o		1 🗆 Yes	2 1 No
al director, page To Be Com		examiner? 1 Tes 2 No	Hospital:	patient 2	] ER/Outpatient	t 3 🗆 D0	Othor				6 □Other (Speci	fv)
- P		27. Manner of Death  1 Natural 5 Pending	28a. Date of	Injury , Day Year)	28b. Time of Injury	- 1	28c. Injury at Work?		28d. Describe			<i></i>
he fur		2 Accident investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,	,,	М		2 □ No				
led in by the funera Certification;		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place o building	of Injury - At h g, etc. <i>(Speci</i>	nome, farm, stre ify)	eet, factor	y, office		28f. Location (S City or Tox		d Number or Rur )	al Route Number,
completely filled in by the		29a. Certifier 1 Certifying Phy- (Check only one) 2 Medical Exami	sician: To the bas ner: On the bas and manne	sis of examin	owledge, death ation and/or inv	occurred estigation	at the time, n, in my opini	date and place on, death occu	, and due to the rred at the time,	cause(s) date and	and manner as s I place, and due to	stated. to the cause(s)
Me		29b. Signature and title of certifier	. >				c. License n		4		e signed (Month,	
		Jane 1	no.				100	546=	36		0/2/.	20011
		70					1 OUL	- 10-			1/0//~	1000
7	;	30. Name and address of person who co	ompleted cause	of death (Ite	m 23a) (Type, i	Print)		2/6-	_		1/0/0	1.21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05295 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February **Physician** Ï', 200̈́4̈́ PATRICK EDMUND KELLY 6:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 124 Emmitsburg Road Thurmont Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Mar. 17, 1930 Maryland 6. Sex 1 □ M 2 □ F **Funeral** Months 215-26-1408 73 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or Itams 23a or 28a-f ehorevent, the Medical Examiner must be notified at or 28a-f show 1 ☐ Yes 2 No Director Maryland | Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 124 Emmitsburg Road 21788 U.S.A. Completed by Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Item any injury or other traumatic event, if a Martin and page. Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 Ϊ No Specify: Specify: Year of Dates: Korea 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Delivery Man Claire Frock 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph W. Kelly Anna Wills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances K. Messner 15740 Kelbaugh Road, Thurmont, Maryland 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory 2/4/04 Smithsburg, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of flurieral Service Licens ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part1. Ent of the disease or some tips shock, or head failure. List only one de ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition The rosclenon L CARDIOVAJE-/on **Physician** 2070101 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) the attending physicien Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a, Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20035152 2004 Mo 30. Name and address of lerson who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Division of Vital Records, P.O. Box 68760

S. CONTER ST

Thurmost, MD

100

32. Registrar's Signature

MD

FEB 0 4 2004

JL. KROVIZ

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2004 05296 State
Registrar Amended #1 perMD FCHD/dc Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Blanche, Naomi Kinna 5,2004 **Physician** February 2:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 反 F Yrs Director 217-80-1223 23, 1919 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Itams 23a or 28a-f ehow the Medical Examiner must be notified at Maryland Frederick Jefferson 1 ☐ Yes ANO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3885 Shadywood Drive 21755 USA filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file.
Depertment of Health and Mental Hy
Important: If Item 27 Is marked oth
eny injury or other treumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be Alonzo G. Ausherman 01ive Mae Jennings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Kinna/Husband 3885 Shadywood Drive, Jefferson, MD 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 2/07/2004 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Pike, Frederick, MD 21702 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Long Libe resulting in death) /Medical Due to (or as a consequence of) **Examiner** 651151 Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events onsequence of) the attending physicien and hed for use as the burial-transit or Attending Physician: . The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2. No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural s after death. 1 ☐ Yes 2 ☐ No in by the 1 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Christopher Fleming, 610 Ninth Street Brunswick, MD 21716 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Co.

	_		For State Registrar	_		or mary	and / Di	epar C <i>erti</i>	ficate of	Death		Reg. N	<sup>e</sup> 2(	304	05297
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Ţ	Examin		4a. Facility Name (If not ATLANTIC					4		r Location of Dea ERLIN	th	40		y of Death	
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- 2/6	or 28a-f	Director	MARYLAND  10e. Street and Number	WORCES			ВЕР	RLIN	10f. Zip Code 21811			10g. C	itizen of	What Count	
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•	Fδ		30. Name and address of		completed cau	se of death	(Item 23a) (To	VDB. Pri	H44	4283		2/	19	100	4
CIH.	8		140621		Dur KI	9	733	He	elhuz	4 Dren	e d	Berl	lan	me	)
	Sta Registr	-	31. Date filed (Month, D		2004	egistrar's S	ignature	Spa	de						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician JAMES EDWARD** KEARNEY January 26, 2004 5:30 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner Prince George's 13022 Bellevue Street Beltsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | March2, 1932 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 217-30-6966 71 Yrs. Washington, D.C. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location Beltsville 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Maryland Prince George's 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13022 Bellevue Street 20705 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status e filed within 72 hours after d il Hygiene. other than "natural", or Item 1 Tyes 2 No
If Yes, Give
Year or Dates: 1960 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🌠 No Specify: ģ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Specialist Federal Government permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event, 0DGs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert W. Kearney Mildred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13022 Bellevue Street Beltsville, Maryland 20705 e of Disposition (Name of Date 20c. Location - City or Town, State Jean G. Kearney -wife 20a. Method of Disposition Place of Disposition (Name of cometery, crematory or other place) 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 1/30/2004 Brentwood, Maryland 21. Signature of Funeral Service Ligensee Donald V. Borgwardt Funeral Home, P.A. Doneld 20 a 4400 Powder Mill Rd. Beltsville, Maryland 20705 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mesothelioma **Physician** chronic disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Be Completed by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy performed? 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 XNatural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Diractor: A investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) th e 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 January 27, 2004 M.D 53(7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Drive, #300 Rockville, Maryland 20878 John M. Wallmark, M.D. 31. Date tiled (Month, Day, Year) FEB 0 3 2004 32. Registrar's Signature State Registrar

State of Manyland / Department of Health and Mental Hygiene-

			Otate of	Maryland / De	Certificate of	Death	Re	2004	05299
	Physici		Decedent's Name (First, Middle, Last)	a			2. Date of Death Month	Day Year	3. Time of Death
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	Funeral Director		5. Social Security Number 294-05-3239  Usual Residence of Decedent  6. Sex 1 □ M 2 □ XF	7. Age (In yrs. last birtho <b>87</b> Yrs	Months Dave		8. Date of Birth (Month, Day, 18	9. Birth Co. 1916 Mo	place (State or Foreign intry) ntana
	yland		10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
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	3a or 2	Dir	10e. Street end Number 9160 Belvoir Woods Par	#240	10f. Zip Code	22060	10	g. Citizen of What Cou U.S.A.	intry :
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Baltimore,	Pages 1 ar		20a. Method of Disposition  1 ☐ Burial 2 ☐ **Eremation 3 ☐ Removal from \$ 4 ☐ Donation 5 ☐ Other (Specify)	SIAIH !	isposition (Name of crematory or other pl			Co. Location - City or T	own, State
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_	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai C	29a. Certifier (Check only one)  1☐ Certifying Physician: To the ba and mann	sis of examination and/o					
	within To the	Me	29b. Signature and title of certifier	C+	29c. Licer	se number	290	d. Date signed (Month	, Day, Year)
	(10)	)		Carren 1	nD 0101	05833	S-VA	2/4/0	<i>†</i>
R			30, Name and address of person who completed caus 8109 Hinson Farm	Cd #504	Alexa	ndriz V	A ZZS	306	
	Sta · Registr	_	31. Date filed (Month, Day, Year)  SEE 0 4 2004	egistrar's Signature	de '				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yeer **Physician** -ambert 154 M 4a. Fecility Name (If not institution, give street and number) 26 2004 01 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Co. Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year)
June 7, If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 3/5XF 577-32-4449 79 1924 VΑ Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or Iteme 23a or 28a-f ehow the Medical Exercise must be notified at 1 X Yes 2 ☐ No Frederick Director Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Peach Orchard Lane 21716 USA Funerai permit. Pages 1 and 2 should be filled within 72 hours after deal Department of Health and Mental Hygiene. Important: If term 27 is marked other thermany injury or other traumer. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wade Umbaugh Maude Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Lambert (Daughter) 318 St. Paul St., Boonsboro, MD 21713 20a. Method of Disposition 20b. Place of Disposition (Name of Country Arematory Strengtony other place) 20c. Location - City or Town, Stete tX Burial ₁2 ☐ Cremation 3 ☐ Removal from State 4 Donetion 5 Other (Specify) Episcopal Church Cem 1/31/04 Pt. of Rocks, 21. Signature of Funeral Service Lice Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD <u> 21769</u> Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause of bach line. Approximate Interval Between Onset and Death Immediate Cause (Final Prenna **Physician** 3 wm Es disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 7 Pulma obline aria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9□ Unknown 9 Unknown signed by t d be detach Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cagertin Henry Fails 1 Yes 2 No 3 Probably 4 Gunknown Completed peeu Artinos lestiz 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Dirtes mallity certificate 1 Yes 2 -No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Yeer) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) P18019 JAV 5) 500W tente ~0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21740 MILLIT HAGERSTOWN MD MD 340 VASANT NO 32. Registar's Signature 31. Date filed (Month, Day, Year) State Registrar EEB U 2 2004

State of Maryland / Department of Health and Mental Hygien 2004 05301 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb. 2, Day 2004 ear 5:30 A **Physician** Anna Mae Loveless /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 6, Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex **Funeral** Months Hours Days Min 212-24-6342 1 ☐ M 2 ☐ F 77 1926 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits 7 is marked other then "naturel", or Items 23e or 28e-t show treumatic event, It e Madrat Examiner must be notified at MD Frederick Frederick 1 □XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1208 Alban Ct. 21703 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 2 should be tiled within 72 hours after and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White þ 3€3€Vidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Olen L. Beachley Flossie Travis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n any injury or other treun once. 7301 Countryside Dr., Middletown, MD 21769 Jacob Loveless (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 2/6/04 1 X Burial 2 Cremation 3 Removal from State 4 Donatio 5 Other (Specify) Frederick, MD Resthaven Memorial Gardens 4 □ Donation Servic Lice 21. Sign sture of DonaTaddB. Thompson Funeral Home E. Main St., Middletown, MD 21769 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on leach line. Approximate Interval Between Onset and Death Cappart Frant faidure CHIZ Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certiticate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Pulm tibrisis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes Hospitel or Attending Physicien: 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 Pending investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 016939 3 64 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M: 63/2-4000 W9 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 5 2004 Registrar

			For State Registrar	State of Maryland		rtment of F			giene Reg. No. 2004	05302
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
Phys	sicia edica		WALTER	AMBROSE	LIDD	ICK			ary 2,200	4 9:46 P <sup>M</sup>
	mine		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	th
			Frederick Memorial	Hospital		Frederi			Frederick	
Fune			5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		thplece (State or Foreign buntry)
Direct	tor		173-09-2033 Usual Residence of Decedent	85				Aug. 4	, 1918 Penr	ısylvania
death with the Maryland ms 23a or 28a-f show			10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
Mar.		ğ	Maryland Frederick	Fred	erick					1Ž Yes 2 □ No
th the		Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
23a 23a			1455 Dockside Ct.			21701		Ţ	United Stat	
er deg		Funeral	11. Walter States	<ol><li>Was Decedent Ever in U.: Armed Forces?</li></ol>		Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
urs afte		by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 AYes 2 □ No If Yes, Give Year or Dates: WWII		☐ Yes 2🌇 No	Specify:		Specify:	
filed within 72 hours after Hygiene. sther than "natural", or ite			15. Decedent's Educ			lent's Usual Occup	pation		Whi 16b. Kind of Business	
nin 72		Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	kind of work done OO NOT use retired	during most of work d)	ing		
d with		E	12	College (1-401 54)	Autom	obile Sa	lesman		Automotive	Industry
d be file		Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Sumame)	
should be nd Mental marked o		1	Walter A. Liddick				Mildred		Eck	
S Pure		1	19a. Informant's Name/Relationship (Typ	ee, Print)					r, City or Town, State, a	
1 and 2 Health am 27 i			Wayne Liddick / s		1455	Dockside	CT. Frede	erick. M	laryland 21	701
Peges 1 nent of H int: If Ite	5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		ametery, cren	sition (Name of natory or other plac	ce)		20c. Location - City or	
permit. Peges Department of Important: If I any Inlury or or or or or or or or or or or or or			' 4 □Donation 5 □ Other (Specify)		derick	Cremato	ry 2/5/2	2004 F	rederick.	Maryland
permit. Peges Department of Important: if it	buce		21. Signature of Funeral Service License	ө •					Jneral Home	
TATLES 13		-	23a. Part1. Enter the disease, or complic	ations that caused the death						land 21702_
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	, 1	. ^				Approximate Interval Between Onset and Death
Physici /Medic	-		disease or condition resulting in death)	4411000	1000	1 Cor	diverc	la a	Trail	Ayors
Examin	er			00 to (01 tas a consequ	101100 017.					
		Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):					
cuted nd ransit		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.							
e exe ien a			resulting in death) Last	Due to (or as a consequ	ience of):					
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o ≝ Ese	3	Me	IF FEMALE:	lo II use sutseme of process	201					
3	6	hysiclan/Me	23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	1		23d. Date of de Month	ivery Day Year
. 0 000		ysic	1 Yes 2 No	9☐ Unknown	Jalli 5	Other (specify)				
The law requires that the tee has been signed by the lags been signed by the lags of 2 should be detached.	3	۵.	Part II. Other significant conditions conf	ributing to death but not resu	ulting in the ur	iderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
w requires that is been signed to should be deti	3	d by						1 □ Y	es 2□No 3□Pr	obably 4 Minknown
w requires to been so should		ompleted						24a. Was a	an 24b. Were au	itopsy findings available
The lay	2	Ë						autops	med? prior to death?	completion of cause of
	Σ ,	0	25. Was case referred to medical				26. Place of Death			2LJ 100
ysician: ysician: is certific director.		0	examiner?	ospital: 1 🗆 Inpatient	ER/Outpatien	3 DOA Oth	er: 4 🗌 Nursing Ho	me 5 Reside	ence 6 Other (Spe	cify)
ding Phy h. After this		ü	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injur Wor	y at	28d. Describe h	ow injury occurred	
Attending at death. Sector: Afte by the fune		atic	2 Accident investigation				Yes 2 □ No			
r Att		ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (S. City or Town	treet and Number or Ru n, State)	ıral Route Number,
itel o	3	O		 						
Hosp Hosp Houne Fune	60	edical	(Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examinat	wledge, death ion and/or inv	occurred at the tire restigation, in my o	ne, date and place, a pinion, death occurr	and due to the c ed at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifics completely filed in by the funeral director.		Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	2	9d. Date signed (Mont.	h, Day, Year)
T. W.T. 8	3		Va ni	( , , , )					2/3/4	
			30. Name and address of person who cor	moleted cause of death (Item	23a) (Tuna	Print)	03/UTP			
5		į	Grad Arth un	(0,2110)	000	mini	KV W	odebon	n) 2	1798
Mary No.	Stat	e	31. Date filed (Month Par Year 201	32. egistrar's Signat	ure A	rack )	1	, , , , , , , ,	1	
Reg	jistra	-	1 25 0 0 200	1 James 1	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa					

State of Maryland / Department of Health and Mental Hygiene 2004 05303

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			1. Decedent's Name (First, Middle, La.	st)					2. Dete of Dea		3. Time of Death
	Physicia /Medic		Hariar	E. Lyle	S				02	03 200	4 0715
	Examin		4a Facility Name (If not institution, give	e street and number)			4		r Location of Death	4c. County of De	ath
			Lorien Nursing H					Mt. Ai		Frederic	
	Funeral Director		5. Social Security Number  214-16-14-8  1  Usual Residence of Decedent	ex 7. Age (In yr	s. last birtho	Months	er 1 Year Deys	If Under 24 Hr Hours Min		<sup>h</sup> , Yeer) 9. Bi 8 1917 Fre	irthplece (State or Foreign Country) ed County, MD
	pue *		10a. State 10b. County	10c. (	City, Town o	or Location					10d. Inside City Limits
	Mary	ō	MD Frederi	ck I	Brunsw	rick					12X Yes 2 □ No
	r 28s	2	10e. Street and Number			10f. 2	ip Code			10g. Citizen of What C	ountry?
	h wit		1002 Peach Orcha	rd Lane			21	716		USA	
21215-0020	is 1 end 2 should be filed within 72 hours after death with the Marylend of Health end Mental Hygiene. Item 27 is marked other then "netural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be multipled at	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	U,S.			lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- orto Rican, etc.)	14. Race - Am Black, Wh Specify: B	nite, etc.
5-0	72 ho	ed	15. Decedent's Ed (Specify only highest gra	lucetion de completed)	16a. D	ecedent's Us	ual Occup	ation during most of w	orkina	16b. Kind of Busines	s/Industry
121	ithin	ald I	Elementary/Secondary (0-12)	College (1-4or 5+)				during most of w f)		D	
	hed w fygier her th	ខ្ញុ	8		нои	sewife	3	10 Mother's N	ame (First, Middle,	Domestic	
Maryland	ntal H	Be	17. Father's Name (First, Middle, Last) Foster Henderson						ene Wilke	·	
Z	d Me d Me mark	၉	19a. Informant's Name/Relationship (		19h M	Aailing Addre	ss (Street			or, City or Town, State,	Zin Code)
Ma	d2s then 7 is 1	- 11	Lana Sewell, Dau							swick, MD	
ē,	ges 1 end t of Health if Item 27 or other to	1	20a. Method of Disposition		_	isposition (N crematory or			Date	20c. Location - City o	
Baltimore,	Page ant cant rt: if		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	) S		ry's C	emete		2/7/2004	Petersvil	lle, MD
Ba	Departm Departm Importar any inju		21. Signature of Fune of Service Licer Barbara A. Will	-USUPENES		John 1	L. WI	lliams I	runeral H oad, Brun	ome swick, MD	21716
	HEAVE !		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the de	ath. Do not	t enter the me	ode of dyin	ig, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between
	Physician /Medical Examiner			a. Congestion Due to Chronic							Onset and Death
	3031A	-	resulting in death)	Due to	(or as a con	nsequence	+ 1.	v-0			
	ted nsit	딭	ě	b. Chronic	Keno	al t	aill	ire			
	artificata be executed ing physician end e es the burial-trensit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	Due to	(or as a cor	nsequence of	}: 	4	ald >	if case	
68760,	siciari b buri	cal	Cause. Enter Underlying Ceuse (Disease or injury that initiated events	. Chronic C	(01.05.0.00F	sequence of		Jiruce	98 2	1/1436	+
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Вох	nding use	2		d							
	death ce e attendi od for use	icla	Part II. Other significant conditions of	ontributing to death but not re	esulting in the	ne underlying	cause giv	en in Part I.	23b. Did t	obecco use contribut	te to the cause of death?
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Vital Records,	s been s s should	Completed b							24a. Was a perfor	an autopsy 24b med?	. Were autopsy findings available prior to completion of cause of death?
<u> </u>	The la	ĕ							101	65 21 NU	1 ☐ Yes 2 ☐ No
/ita	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?						eath (Check only or	ne)	
of \	Physician: rthis certific ral director,	2	1  Yes 2		☐ ER/Outpa			ursing		lence 6 Other (Sp	ecify)
ouc	aling P. After t funera	ü	27. Menner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Tim Inju		28c. Injun Work	yat k? Yes 2 ∐ No	28d. Describe h	ow injury occurred	
Division	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completaly filled in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		home, farm cify)				28f. Location (S City or Tow	Street and Number or F m, Stete)	Rural Route Number,
	Hospita 24 hours Funeral staly filled	edical C					curred at the time, date and place, and due to the cause(s) and manner as stated. tigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)				
	o the	₹	29b. Signature and title of certifier	2		2	9c. Licens	e number		29d. Date signed (Mor	nth, Day, Year)
	F S F Ö		6	Saint			D.3	3064-1		Fe brunra	4 20041
	\	T	30. Name and eddress of person who	completed cause of death (It	em 23e) (Tv	(pe, Print)	1		0	Coración	1 1
			Ramesh Sabal 31. Date filed (Month, Day, Year)	DATH 240 32. Registrar's Sig		dmar	, A	ienue	Baltin	nove Man	4 2004- yland 21213
	Sta Registra		GRO A	52. Hegistial 5 Sig	2		#F .				

			1 - For State Registrar	State of	Marylan	d / Depa	artmen rtificat	t of H	lealth a	and M	ental Hy	giene Reg. No	200	14	05304
	Physici	an	Decedent's Name (First, Middle,	· ·							2. Date of De. Month	ath Da	v Y	eer .	3. Time of Death
	/Medic		Audrey Ra	=	Langwa	У	T =				Janua	ry	30,2		8::30A <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, 4801 Olympia Av		iber)				Location o				County of		1
	Funeral				7. Age (In yrs. I	ast birthdey)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birl	th			orge's
П	Director		223-42-5724	1□M 2 <b>X</b> F		67 Yrs.	Months	Days	Hours	Min.	Month, Oa July9, 1	y, Year) 936		Sout	ece (Stete or Foreign try) h Dakota
	pu ,		Usuel Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	nation								
	Aanyla r sho	ō		George's	1	tsvil								"	od. Inside City Limits  1 ☐ Yes 2 ☐ No
	the P	Director	10e. Street and Number	George 5	Der	LCSVII	10f. Zip	Code				10a, Cit	izen of Wh	at Coun	
	h with		4801 Olympia Av	enue					705				Jnite		
	deat	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S	S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spec	cify Yes or No Rican, etc.)		14. Race -		an Indian,
36	or its		1 Never Married 2 Marrie	d 1 ☐ Yes If Yes, Give	2 XNo	1	1□Yes		Specify:	,, , , , , , , , , , , , , , , , , , , ,	110411, 010.7		Specify: V		
00	72 hours after death with the Maryland naturel; or tems 23e or 28e-f show oral Examiner must be notified at	ed by	3 Widowed 4 Divorced	Year or Da	ites:	16a. Deced		<i>A</i>	ation			16h K			
15	n na n na Nedic	plet	(Specify only highest	grade completed)	45-1	(Give	kind of wor DO NOT us	k done o	furing most	t of workin	19	100. K	ind of Busi	ness/ind	ustry
212	giene. er then "	Completed	Elementary/Secondary (0-12)	College (1-	-401 5+)	Homen	naker						own h	nome	
Maryland 21215-0036	be filed vial Hygie d other i	Be	17. Father's Name (First, Middle, La RAymond N. Nelse								(First, Middle,		Sumame)		· · · · · · · · · · · · · · · · · · ·
yla	2 should be and Mental is marked or	2													
Mar	d 2 sh th and 7 is m traum				المسمام										
	1 and Health Iem 27		20a. Method of Disposition	, srnu	20b. PI	ace of Dispo	sition (Nan	e of		e Bel	tsville	e, M	aryla cation - Cit	or Toy	20705 vn. State
JOI	Pages nent of int: if its		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State												
Baltimore,	그 문문을 .		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Harry G. Langway, Sr. –Husband  20a. Method of Disposition  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  4801 Olympia Avenue Beltsville, Maryland 20705  20b. Place of isposition (Name) Date 20c. Location - City or Town, State												
Ö	Depa impo eny ii	9 9	Moneld U	Bugu	rand	44	onalic 100 Pc	wder	Borg Mil	vardt 1 Rd.	Funera Belts	al H Vill	ome, e. Ma	P.A.	and 20705
g.	The second		23a. Pert1. Enter the disease, or co shock, or heart failure. List or	omplications that canby one cause on ea	used the death ich line.	. Do not ent	er the mode	of dying	g, such as	cardiac or	respiratory ar	rest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_ a Chro	onic Obs	struct	ive P	ulmo	nary	Dise	ase				Onset and Death  10 years
	/Medical Examiner		resulting in death)	Due to (d									1.0 1 0010		
, 4		er	Sequentially list conditions, if any, leading to immediate	equentially list conditions, any, leading to immediate ause. Entar Underlying ause (Disease or injury											
	d d ansit	Examiner	Cause (Disease or injury that initiated events												
oʻ	ate be executed hysicien and the burial-transit	EX	resulting in death) Last	CDue to (c	or as a consequ	ence of):								-	
8760,	icate be executed physicien and s the burial-transit	Physician/Medical	•	d								71.			
9	death certific e attending p	/Me	IF FEMALE:	23c. If yes, outo	ome of prognar	201							7.7		
Вох	thet the death certific ed by the attending p detached for use as	clan	23b. Was decedent pregnant in the past 12 months?	1 Live bir	rth 2 ☐ Fetal unt at time of de	death 3	Ectopic pre					2	3d. Date o Month		y Day Year
o.	the d y the ached	ysk	1 □ Yes 2 1 No 9 □ Unknown	9☐ Unkno		3	Other (spe								
Δ.	= 00	by P	Part II. Other significant condition	s contributing to dea	ath but not resu	lting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco u	se contribu	ite to the	cause of death?
rds	w require been sig should b										¹ <b>☆</b> Y	es 2[	□No 3[	Proba	bly 4 □Unknown
of Vital Records,	as 2	Completed									24a. Was a		24b. Wer	e autop	sy findings available
<u> </u>	The ate h	Con									perfor	med?	dea	th?	pletion of cause of □ No
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Massitali				100		of Death (	(Check only or				
of	두 두 등	2	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 🗆 In		PVOutpatien 28b. Time of		-	4 LI Nur		e 5 x Resid			Specify)	
	ding h. After funer	tlon	1 Natural 5 Pending 2 Accident investigat	(Month	Day Year)	Injury	M	C. Injury Work	al ? es 2.⊟N		3d. Describe h	ow injury	occurred		
Division	or Attending after death. Director: Afte in by the fune	Certification:	3 Suicide 6 Could no determine	be 28e. Place	of Injury - At hor	ϻe, farm, stre					3f. Location (S	treet and	d Number o	or Rural i	Route Number,
Ö	s after s after al Director	Cert	4   Homicide	buildin	g, etc. (Specify)	)					City or Tow	n, State)			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the teminer: On the ba	pest of my know	viedge, death	occurred a	it the tim	e, date and	place, an	nd due to the c	ause(s)	and manne	r as sta	ted.
	To the P within 24 To the F complete	Med		and manne	er stated.	017 4114 01 1119	_								
•	To With		29b. Signature and title a Certifier				29c.	D240			2		signed (M		
^	(2)		30 Name and address of same in	no completed	of death the	2201/15	Deine'					Jan	uary	50,	2004
K	9		30. Name and address of person wh Mark Parkhurst,	M.D. 571	1 Sarvi	S Aver.	ue Ri	verd	lale.	Marv	land 20	1737			
'n	Sta	te	31. Date filed (Month, Day, Year)	9 Do	gistrar's Signatu					- mil y	-u.u. 2(	,,,,,			
	Registra	310	FEB 0 3 20	U4 //	K	No. Be	61								

			1 - For State Registrar	State of N	/larylar	id / Depa <i>Cei</i>	artmen tificate	t of H	ealth a	and M	lental Hyg	iene	200	4 053 <b>05</b>
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  John Earl Loga	n							2. Date of Deat Month 01	Dey 26	2004	3. Time of Death 2:00 P. M
	Examir	er	4a. Facility Name (If not institution, give to 6901 Fawn Crest D	r.			Capi	tal	Heigh	nts		Pı		Georges
	Funeral Director		5. Social Security Number 6. Septimber 193-03-5501	M 2 F	87	last birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birth	Ĭ916	9. Bir Per	thplace (State or Foreign ountry) insylvania
	e Maryland Ba-f ehow Lilled at	ctor	10a. State 10b. County MD Prince G	eorges		y,TownorLo ital H		s						10d. Inside City Limits ty⊠Yes 2 □ No
	3a or 26	ai Dire	10e. Street and Number 6901 Fawn Crest D	r.			10f. Zip	Code 0743			10	og. Citizen US	of What Co	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptyglene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f ehow apply injury or other traumatic event, the Medical Evantical must be notified at once.	by Funeral Director		12. Was Deceder Armed Forces 1 X Yes 2 If Yes, Give Year or Dates	s? ]No		Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto i	ecify Yes or No- Rican, etc.)		Black, Whit	erican Indian, te, etc. 31ack
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)			life. L	tent's Usua kind of wor DO NOT us Accou	k done d e retired,	uring most )	of workii	ng		of Business	,
Maryland 2	should be filed within nd Mental Hygiene. i marked other than "umatic event, ins Ms.	To Be Co	17. Father's Name (First, Middle, Last)  Cary Logan						18. Mothe		(First, Middle, M			116
e, Mar	is 1 and 2 sho of Health and Item 27 Is m- other traum		Muriel Logan/Wife  20a. Method of Disposition	pe, Print)	20b. F	6901	Fawn	Cre	st Dr	., (	d Route Number, Capital l	Heigh	nts, M	
Baltimore,	vit. Pages artment of ortant: If It injury or o		1 ⊠Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	_				mete	ry 0	1/31	./2004	Brent	wood,	Maryland
Ba	permit. Departr Imports eny inje		23a. Panti. Enter the disease, or compli	all		7	474 L	ando	ver R	d.,	. Jenkii Landovei	c, MD	neral 207	
8760,	Physician /Medical Examiner and physician and physician and the price and the price is the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price of the price	dical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that infit	Due to (or a	ronic saconseq perte saconseq	nsion uanca ol).	Fail	ure						Interval Between Onset and Death
P.O. Box 6	it the death certifica by the attending place tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Ideath 3	Ectopic pre Other (spe					23d.	Date of del Month	ivery Day Year
	w requires that I been signed by should be deta	þ	Part II. Other significant conditions con Chronic Obstructiv					use give	n in Part I.			acco use d		the cause of death?
al Reco	: The law recate has been page 2 sho	Completed	Alzheimer's Diseas	se							24a. Was an autopsy perform	ed?	4b. Were au prior to death? 1 \(\sum \text{Yes}\)	topsy findings available completion of cause of
Division of Vital Records,	Attending Physician: The law requires that the death certificate be executed to death.  croseth.   Certification; To Be	examiner?  1									Sify)			
Ď N	To the Hospital or Attentwithin 24 hours after deati To the Funeral Director: completely filled in by the		3 Suicide 6 Could not be determined		etc. (Specify	()					City or Town,	State)		ral Route Number,
	the Hospin 24 hother Fundament	Medicai	29a. Certifier 1⊠ Certifying Phys (Check only one) 2 Medical Examin	ician: To the bes ier: On the basis and manner s	of examina	wledge, death tion and/or inv	estigation,	in my op:	inion, death	place, a	nd due to the cau id at the time, dat	use(s) and e and plac	l manner as ce, and due	stated. to the cause(s)
	or or or or or or or or or or or or or o	2	29b. Signature and title of certifier	2 C	id	elsor	~	License	number	D.	29	1 /	aned (Month	2004
_	(10)		30. Name and address of person who con Edward Adelson M.I					. #50	06 Wa	shin	gton, DC	200	036	
	Sta Registr	-	31. Date filed (Month, Day, Year) FEB 0 3 2004	32. Regis	trar's Signa	ture	e							

			1 - For State Registrar			l / Depa	ırtmen	nt of H		d Mental Hy	/aien	_		05306
À	Physici /Medic Examir	cal		ND re street and number)		Paper		54	Location of E	114	D A	ay Ye	Death	
6	Funeral Director		5. Social Security Number 6. S 172-32-0885 Usual Residence of Decedent	WEIM OFF	65	st birthday) Yrs.	If Under Months	Days	Hours	Hrs/ 8. Date of Bi Min. /Month, D JAN . 15	rth ay, Year 19	9.	Birthpla Countr PENI	ce (State or Foreign VSYLVANIA
	death with the Maryland ims 23a or 28a-f show if must be fortified at	Director	DE SUSSEX  10e. Street and Number  RD #2, BOX 325			Town or Lo		Code 199	4.7		10g. C	itizen of Wha		d. Inside City Limits 1 ☐ Yes 2 ☐ No y?
9036	72 hours after death ratural, or Items 23	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		l lf	Vas Dece Yes, spe	dent of Hi cify Cubai		? (Specify Yes or No uerto Rican, etc.)	0-	14. Race - A Black, V Specify:	Vhite, et	
d 21215-0036	filed within Hygiene. Nther then "	<b>Completed</b>	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last	ade completed)  College (1-4or 5-	+)	16a. Deced (Give i life. D	ond of wo	rk done d se retired) TTER	uring most of	working  Name (First, Middle	AIR			stry JFACTURING
Maryland	2 should be and Mental is marked o	To Be	THOMAS R. LAMON	D Type, Print)				(Street a	ANN.	A URBADO	er, City	or Town, Stat		
Baltimore, N	Pages 1 and 3 nent of Health ont: If item 27 iry or other trans.		ROSE ANN LAMOND  20a. Method of Disposition  1 KBurial 2 Cremation 3 Communication 5 Other (Special Communication)	Removal from State	cen	ce of Dispos netery, crem	sition (Nar atory or o	ne of other place		2, GEORGE' Date 26-04	20c. L	N, DE 1  Location - City  LTON,	or Tow	
Balti	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licer	ort	0000	22.	Name an	d Address	of Facility	SHORT FU	NERA DE	L SERV		3
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Due to (or as a	e. Lçonseque	brace of):	r the mod	le of dying	, such as car	diac or respiratory a		lid	lr.	pproximate iterval Between inset and Death inset and Death
3760,	ate be executed hysicien and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	Hr	S							10	· yu
P.O. Box 68	The law requires that the death certifica Ite has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal d	eath 3 🗌	Ectopic pr Other (sp					23d. Date of Month	delivery Da	ay Year
Records, P	w requires that been signed t should be det	by	Part II. Other significant conditions of	ontributing to death bu	t not result	ing in the un	derlying c	ause give	n in Part I.	23e. Did t				cause of death? ly 4 ∐Unknown
al Reco		Completed								1 Yes	osy ormed? 2 No	prior death	to comp	findings available letion of cause of
Vita	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	۰ ۵۵۰	2/0-4	•□••	Other	**	Death (Check only o				
ion of		ation; To	27. Manner of Death  1 Datural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	/ 2	NOutpatient 8b. Time of Injury		8c. Injury Work	4   Nursin	g Home 5 Resi			pecify)	
Division	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not b 4 Homicide determined	building, etc.	(Specify)	2-11-2				28f. Location ( City or To	vn, State	e)		
•	he Hospite n 24 hours he Funeral pletely fillec	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of niner: On the basis of e and manner stat	examinatio	edge, death n and/or inve	occurred estigation,	at the time in my opi	e, date and pl nion, death o	ace, and due to the ccurred at the time,	cause(s date an	and manner d place, and d	as state fue to th	ed. e cause(s)
•	To the within To the comple	W	29b. Signature and title of defittief	lea-19			290	License	number	109	29d. Da	ate signed (Mo	onth, Day	y, Year)
Sa			30. Name and a less of person who	completed cause of de	ath (Item 2	3a) (Type, P	rint)	50	lich	109 14, MD	27	1804		
4	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 9 20	32. Registrar	's Signatur	° 19	Spi	aks	1	7, 111		No. I		

DHMH 17 Rev 1/2001

Robert Lamind

State of Maryland / Department of Health and Mental Hygiene 05307 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician**  $\mathbb{A}^{\text{M}}$ 0832 Diane Guetschow Loller February 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Elkton Union Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 🕅 F 62 May 27, 1941 Maryland Director 213-38-6728 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ral', or items 23a or 28e-f show Exemples out be notified at 1 ☐ Yes 2 No Maryland North East Cecil Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 78 Red Toad Road 21901 Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 🕅 No permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other treumatic event, the Madical Ext. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify ff Yes, Give Year or Dates Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Colfege (1-4or 5+) Homemaker In Her Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hattie Blanche 2 Herbert Guetschow 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James E. Loller/Husband 78 Red Toad Road, North East, Maryland 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State February 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery \* 4 □ Donation 5 □ Other (Specify) 14, 2004 Earleville, Maryland 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Sérvice Licenses 1103 W. Stockton Street, Elkton, Maryland 21921 Part 1. Enfor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only are caused in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical e to (or as a consequence of) Examiner 1erboten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transil dyan 0 the attending physician and Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year jo 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I 3 probably 4 □Unknown 1 🗌 Yes 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐ Yes 2 ILNO or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 2 1 No 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [ 1 Peritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTILAL ELMI) 23 SINGERL 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

1 9 2004

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

D: .		1 - State Amended#1  1. Decedent's Name (First, Middle, Las	State of Marylan				2. Date of Death Month		0530
Phýsic /Medi		Richard Alan Ma						31, 2004	1:05 p
Exami		4a. Facility Name (If not institution, give				or Location of Dear	th	4c. County of Deat	h
		5603 Broadmoor Te  5. Social Security Number 6. Se		la et hirthday)	Ijamsvi If Under 1 Yea			Frederick	(0)
Funeral Director			ZM 2□F 51	Yrs.	Months Days			952 New	hplace (State or Forei unitry) Jersey
Mo W		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limi
He de	iot	Maryland Frede	erick I	jamsvi	11e				1 □ Yes 2 🛣 N
Sa or 28	i Dire	10e. Street and Number 5603 Broadmoor Te	errace, N.	-	10f. Zip Code 21754		100	g. Citizen of What Co U.S.A.	untry?
182	nera	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No-	14. Race - Ame	
l', or ite	by Funeral Director	1 Nover Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cu 1 ☐ Yes 2 🛣 No		to Hican, etc.)	Black, White Specify:	e, etc. white
ical E	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occu	upation	deina 16	6b. Kind of Business/	Industry
Men "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir	*			
tygier her th	S	17. Father's Name (First, Middle, Last)	5+	Vice	Presiden			ightstyles	s, Inc.
Department of Health and Mental Hygiene Interns 23s or 28s-f show important: if item 27 is marked other than "ratural", or items 23s or 28s-f show amportant: if item 27 is marked on the ratural to rottling at 2008.	To Be	James Marion					me (First, Middle, Ma ara Bloch	aiden Sumame)	
alth and 27 is m r traum		19a. Informant's Name/Relationship (7 Lauren Marion - wi						City or Town, State, 2 msville, N	
of He if item ir other	-	20a. Method of Disposition 1 ☐ Burial 2 ☐ € Cremation 3 ☐	1 6	lace of Dispo	sition (Name of natory or other pla	ace)		Oc. Location - City or	Town, State
ant: f	l	`4 □ Donation 5 □ Other (Specify	Fre		Cremato	- ,		rederick,	-
Depart Import any In		21. Signature of Funeral Service Licens	11 //					neral Home	
0240		23a. Part 1. Enter the disease, or comp	lications that caused the death					erick, Mar	yland
		shock, or heart failure. List only o	one cause on each line.			ing, such as cardia	c or respiratory arres	T,	Interval Between Onset and Death
nysician Medical		disease or condition resulting in death)		CANCI	1				17 MINTHS
xaminer			Due to (or as a conseq	uence or):					
1-44	Jer	Sequentially list conditions, 1 any leading to intractiate cause. Enter Underlying	b. Due to (or as a conseq	ienca of):					
ysician and ie burial-transit	Examiner	that initiated events	c.						
urial-	EX	resulting in death) Last	Due to (or as a conseq	uence of):					
	dicai		d						
igned by the attending physician and be detached for use as the burial-transit	by Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	nev	-				
atten for u	cian	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d	death 3	Ectopic pregnand Other (specify)	су		23d. Date of deli- Month	very Day Year
y the ached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	Jan. 0 _	Ciriei (apociny)				
ned b	y Pi	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause g	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Sign of b							1 🗆 Yes	27€No 3 Pro	bably 4 Unknov
E =	Completed						24a. Was an	24b. Were au	topsy findings availab
ss been si 2 should l	E O						autopsy performe	death?	ompletion of cause o 2⊠No
ate has been page 2 shoul	(a)	25. Was case referred to medical examiner?				26. Place of Dea	ath Check on one		7
ertificate has been ctor, page 2 shoul	100	1 ☐ Yes 2 No	Hospital: 1   Inpatient 2	ER/Outpatien	1 3 DOA	ther: 4 Nursing H	lome 5 Residence	ce 6 □Other (Spec	ify)
his certificate has been il director, page 2 shoul	To B		28a. Date of Injury (Month, Day Year)	28b. Time of Injury		ork?	28d. Describe how	injury occurred	
After this certificate has been uneral director, page 2 shoul	2	27. Manner of Death 1 ☑Natural 5 ☐ Pending	M 1 ☐ Yes 2 ☐ No				296 Lagation (Ctra	at and blomba and Do	and Double Mirror
n. After this certificate has funeral director, page 2	2	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	29a Place of laiun. At he			1	City or Town,	et and Number or Ru. State)	rai Houte Number,
after death.  Director: After this certificate has been tin by the funeral director, page 2 shoul	2	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28e. Place of Injury - At he building, etc. (Specify	me, farm, str	eet, factory, office		Only or Town,		
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nysicia	an	1. Decedent's Name (First, Middle, Las					2. Date o		ay Year	3. Time of Dea
Medic		Pauline Frances  4a. Facility Name (If not institution, give			4b. City, Town,	or Location of I		Mary	c. County of Death	
kamin	er	Washington County				stown	Douth		Washing	
neral		Social Security Number     6. Security Number	7. Age (In yrs.	. last birthday,		r   If Under 24	Hrs. 8. Date o	f Birth , <i>Day,</i> Year		nplace (State or Fountry)
ector		219-20-0628 1 Usual Residence of Decedent	□ M 2 🖾 F 93	Yrs.	Moritis	Nouis	May	8, 19		ryland
=		10a. State 10b. County	10c. Ci	ity, Town or L	ocation					10d. Inside City Li
tiffed	ctor	Maryland Washi	ngton	Hager	rstown					1 □ Yes 2 🗵
event, the Medical Examiner must be notified at	Directo	10e. Street and Number 17320 Lexington	Avenue		10f. Zip Code	L740			itizen of What Cou SA	untry?
TRUBE	Funerai	11. Marital Status	12. Was Decedent Ever in U	J.S.   13.			n? (Specify Yes o		14. Race - Amer	ican Indian.
rranar		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		Was Decedent of If Yes, specify Cull 1 ☐ Yes 2 🖾 No		Puerto Rican, etc.	)	Black, White	
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edice	Completed	15. Decedent's Ed (Specify only highest grades)	de completed)	16a. Dece (Give	edent's Usual Occu e kind of work done DO NOT use retire	upation e during most o ed)	f working	16b. k	Kind of Business/li	ndustry
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vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Mic	ddle, Maider	n Sumame)	
matic e	2	Roy Hayes Parlet		_		Cora	E. Bowa	rd		
3 1		19a. Informant's Name/Relationship (7) Frances Miner - (			ing Address (Stree					
other tr		20a. Method of Disposition			20 Lexing osition (Name of smallery or other place)		Date	-	ocation - City or T	
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dical iner	ai Examiner	Immediate Cause (Final disease or condition	a. <u>Aeuli</u>	th. Do not enter and aut. quence of):	ter the mode of dy	ing, such as ca	rdiac or respirator	ry arrest,		Approximate Interval Between
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Date of delive Month  use contribute to the contribute to the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribute of the contribu	Approximate Interval Between Onset and Deal Onset and Deal 3 down on the cause of death bably Day Year Day Year Day Year Day Year Day All House Office of the cause (s) Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Year Day, Yea

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 1:40 Am February 2004 Kenneth Lester McCullough 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Washington 16505 Virginia Avenue If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. 31, 19 Birthplace (State or Foreign Country) **Funeral** Days Hours 10XM 2□ F Yrs. Director 217-07-6679 92 1911 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue 21795 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 M Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔯 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrician Aviation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be f h and Mental I Samuel Negley McCullough Grace Caroline Newcomer and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: if item 27 is Barbara A. Mueller/Daughter 2173 Warm Springs Road, Shenandoah Jct. 25442 WV Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ŏ 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) 2/9/2004 Rest Haven Cemetery Harerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel SMark 1601 Pennsylvania Avenue, Hagerstown, Md. 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one chuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 Years Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atten 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown مَ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? À Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? Yes 2/2/No certificate 1 ☐ Yes 1 Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Selection 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA ctor: After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director 3 🗌 Suicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H-UX1 200 D27949 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11110 Medical Campus Drive, Hagerstown, Md. 21742 Steven Hatleberg 31. Date filed (Months Day, Year) 32. Registrar's Signature State

Registrar

			For State Registrar	State of Maryland	l / Depa <i>Cer</i>	rtment of H	ealth and Me Death	ental Hygi	ene 200L	05311
2	Physicia	an	1. Decedent's Name (First, Middle, Last)					<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death 2:30 AM
	/Medic	al	John Mas  4a. Facility Name (If not institution, give si			4h City Town or	Location of Death	Feb 1,	2004 4c. County of Oeet	
	Examin	er	Pineview Nursing			Clinton	LOGGRION OF BOSE		Prince G	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9 Birt	hplece (State or Foreign untry)
<b>i</b> .	Director	j		M 2□F 79	Yrs.			Feb 11,		yland
	land land		Usuel Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary	tor	Maryland Prince G	eorge's	Up	per Marl	oro			1 □ Yes 2 □ No
	or 284	Director	10e. Street and Number	D:		10f. Zip Code	7 /	10	g. Citizen of What Co	
	a 23a	erail	3321 Poplar	2. Was Decedent Ever in U.S	13 V	2077	spanic Origin? (Spec	city Yes or No-	United	
10	72 hours after death with the Maryland natural; or Itema 23e or 28e-f ehow deat Exambrar must be troffled at	Funeral	11. Marital Status 1 Never Married 2 Married 1	Armed Forces?  1 Tyes 2 No 194  If Yes, Give	43	Yes, specify Cuba	n, Mexican, Puerto F	lican, etc.)	Black, White	e, etc.
5-0036	ral', o	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 194	46	Yes 2 No	Specify:		Specify: Af  Am 6b. Kind of Business/	
15-0	n 72 h natu	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced (Give life. L	ent's Usual Occupa kind of work done of OO NOT use retired	ation Juring most of workin )	g 1	6b. Kind of Business/	Industry
2121	within iene. r then	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	Petro		,	-	Self Emplo	yed
	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. int: If item 27 le marked other than "natural; or itema 23a or 28a-f show yor other traumatic event. The Medical Examiner must be recilied at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name			
yla	ould b Ment harked	T <sub>o</sub>	Charles A. Maso		40h M-11	- 4 1 1 / (2 1 4 1	Lula Que			Zin Codo l
Maryland	d 2 sh th and th and 7 le m traum		19a. Informant's Name/Relationship (Type Catherine Mason	(Wife)					City or Town, State, 2	
	s 1 an f Heal item 2 other		20a. Method of Disposition	20b. Pl		sition (Name of natory or other place			Oc. Location - City or	
mo	Page nent o ant: If ury or		1 DBurial 2 □ Cremation 3 □ Ro 1 □ Other (Specify)	emoval from State   _	surrec	tion Ceme	etery		Clinton, M	
Baltimore,	permit. Page Department Important: Il eny injury o		21. Signature of Funeral Service License	14 - 51 10	22				Home,Inclinton, MD	
W.	40 = 0		23a, Part1. Enter the disease, or complin	MOODTA	Do not ente					Approximate
	Dhusisian		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		,	•			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	ence of):					Lwest
5,	Examiner		Sequentially list conditions.	AThero	scler	offic (	ndiouna	la Mis	en	2 ylans
8	ed ssit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (of as a consequ	ence of):					0
,	be executed sician and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequ	ence of):					
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical								
9	n certifica anding ph use as th	Med	IF FEMALE:							
Вох	attend for us	Physician/Med	in the past 12 months?	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	Day Year
o.	t the de by the tached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown						
s, P	es that igned t be det	by P	Part II. Other significant conditions cor	stributing to death but not resu	Iting in the u	nderlying cause give	en in Part I.		acco use contribute to	VV
ord	w require been si should I							·	s 2□No 3□Pr	
Records,	e law has b	ompieted						24a. Was ar autops perform	prior to	itopsy findings available completion of cause of
lal		e Co	25. Was case referred to medical				26. Place of Death	perform		2 No
f Vital	yaic is ce direc	To B	avaminar?	lospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	nt 3□ DOA Oth	00		nce 6 □Other (Spe	cify)
n of			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		8d. Describe ho	w injury occurred	
sio	or Attending ifter death. Director: After in by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me farm str		Yes 2 □No	28f Location (St	reet and Number or Ri	ural Route Number.
Division	or Attendate death after death I Director;	Certification:	4 Homicide determined	building, etc. (Specify		eet, factory, office		City or Town		4
	To the Hospital of within 24 hours at To the Funeral D completely filled in		29a. Certifier XXXX Certifying Physical Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat	wledge, deatlion and/or in	h occurred at the tir vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the ca	use(s) and manner as	s stated. to the cause(s)
	thin 24	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens			d. Date signed (Mont	
	F ₹ 8		1 116	i/	)	104	45365		eb 2, 2004	· '1
	1		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type,	Print)	7,00	Y X	CD 2, 2002	
Y	B2:1		Michael G. Sidar	ous, M.D. 1170	)1 Liv	ingston R	load #101,	Fort Wa	shington,	MD 20744
200	St Regist	ate rar	31. Date filed (Month Day) 6 2	32. R. distrar's Signa	K.	barke				

	Physici	an	1 - State Ragistrar Amend Item# 24a  1. Decedent's Name (First, Middle, Last	)	282/26		rtifica	te of		2.	Date of Death Month	g. No. 20	04 05312 (ear 3. Time of Death
	/Medic Examir	al	4a. Facility Name (If not institution, give  Harbor Hospit  5. Social Security Number 6. Se	street and number)	1 te		4b. City		r Location of i	Death Orl	Pate of Birth	4c. County of NONE	Death
	Funeral Director			х ] м 2 <b>Т</b> F	31	Yrs.	Months			Min. AU	IGUST 1	4,1972	B. Birthplace (State or Foreign Country)  MARYLAND
	e Maryland sa-f ahow	Director	10a. State 10b. County  MARYLAND NONE			ty, Town or Lo						- 8	10d. Inside City Limits  XXYes 2 □ No
	ith the	Dire	10e. Street and Number				10f. Z	ip Code			100	g. Citizen of Wh	at Country?
036	d 2 should be filed within 72 hours after death with the Maryland it and Mantal Hyglene. It is marked other than "netural", or items 23e or 28e-f ahow traumatic event, the Madical Examinar must be notified at	by Funeral	3748 ST. MARGARET  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 1 1 If Yes, Give Year or Dates:	Ever in U		_	212 edent of H ecify Cuba 2XI No	225 ispanic Origin an, Mexican, f Specify:	n? (Specify Puerto Rica		Black,	ATES American Indian, White, etc.
21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ication le completed) College (1-4or 5	+)	16a. Deced (Give life.	kind of w	ual Occup ork done o use retired	during most o	of working	16	6b. Kind of Busin	
2	filed wil Hygien other th	Con	12TH GRADE			CLERK	/ 0	FFICE	E MANAC	GER		BUSINES	S INDUSTRY
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Mai	d 2 sho	1 4	19a. Informant's Name/Relationship (T) DORIS COOPER / MOT	THER		7						City or Town, Sta	
	1 an Heal em 2		20a. Method of Disposition	. NEK	20b. F	Place of Dispo	sition (Na	me of	1	LAUI Date	REL, MA		20724 ty or Town, State
JO.			1  Surial 2  Cremation 3  F '4  Donation 5  Other (Specify)		0	semetery, cren	natory or	other plac		TTD 10			
Baltimore,	permit. Pages Department of Important: If I any Injury or 9006.		21. Schature of Funeral Society Lice		_	T. 22	Name a	TON F	ss of Facility UNERAL	HOME	E. P.A.		IE, MARYLAND
	Physician /Medical Examiner	her	23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ications that caused ne cause on each line.  Due to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or as a bull to (or a	dica conseq	Denot entropy $Pu/v$ , uence of):	n or	de of dyin	g, such as ca	Arre	spiratory arres	t,	MARYLAND 2064 Approximate Interval Between Onset and Death Min U FRI
68760,	tificate be executed g physicien and as the burial-transit	edicai Examiner	Cause (Disease or injury	Due to (or as a	a conseq	uence of):							
.O. Box (	death cer e attendin id for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Feta	Ideath 3□	Ectopic   Other (s	pregnancy				23d. Date o Month	
s, p	es be	Ď	Part II. Other significant conditions co	ntributing to death bu	ıt not res	ulting in the ur	nderlying	cause give	en in Part I.				ute to the cause of death?
Vital Record		Completed								_	24a. Was an autopsy performe	d? prio	re autopsy findings available in to completion of cause of th?  Yes 2 \sum No
/ite	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	leasitel.						Death (Ch	neck only one)		
	d is	ို	TES ZIZINO	Hospital: 1 ☐ Inpatie	-	ER/Outpatien			4   Nursi			ce 6 Other	(Specify)
Division of	Jing After fune	ertification;	27. Manner of Death  1 Natural 2 Accident 3 Suicide  2 Could not be	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	М		/ at (? Yes 2 □ No			injury occurred	0.710.004
Div	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	OL	4 Homicide	28e. Place of Injubulding, etc	. (Specify	y)				1	City or Town, S	State)	or Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Aedical	one)	sician: To the best oner: On the basis of and manner sta	examina	wledge, death tion and/or inv	estigatio	n, in my op	oinion, death	olace, and o occurred at	t the time, date	and place, and	I due to the cause(s)
•	To the within To the comple	Σ	29b. Signature and title of certifier	D.U.			- P	c. License	556 (	62	-	. Date signed (A bruary	Month, Day, Year) 4 2004
*	3B5		30. Name and address of person who could be $\mathcal{S} \cup \mathcal{S} \cup \mathcal{A} \cup \mathcal{M}$ ,	ompleted cause of de MAS+	eath (Item	23a) (Туре, I О И -С	Print)	. 0 .	3661	Surt		e/ 31.	Baltmore, Mil
	Sta		31. Date filed (Month, Day, Year) FEB 0	32. Registr	s Signa	ture #	10	ed.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05313 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28 2004 **Physician** Margaret T. Metz January 11:30 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 6. Sex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 15,1920 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country)
 New Jersey **Funeral** 1 □ M 2 X F Days Hours Director 216-80-4433 83 Usuel Residence of Decedent 10a. State ahow 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Exeminer must be notified at 1 Yes 2 No Director Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itams 23a 12411 Stirrup Lane 20715 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married ò 1 ☐ Yes 2 No Specify: Specify: White 3 N Widowed 4 □ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker . Pages 1 and 2 should be filed w tment of Health and Mental Hygier tent: If item 27 Is marked other th jury or other treumatic avent. ILs 4 Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marion Tyminski ပ Kathleen Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard H. Metz / Son 12411 Stirrup Lane Bowie, MD. 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or ance. Metropolitan Crematory 1-30-2004 Alexandria, VA. ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Highway Bowie. MD. 20715 wan due 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction 1-2 hrs /Medical Due to (or as a consequence of) **Examiner** Coronary Artery Thrombosis 1-2 hrs. Sequentially list conditions, I any leading 13 in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cua to (or as a nonsequence of)-Examiner The law requires that the death certificate be executed burial-transil Coronary Atherosclerosis unknown Due to (or as a consequence of): Physician/Medical Hyperlidemia unknown the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hypertension 3 Probably 4 Unknown 2 No 1 ☐ Yes Mitral Valvular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe Yes 21 1 ☐ Yes 2 ☐ No Hospitel or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funeral Directors of Funera 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and lace, and due to the cause s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and tile of certifier 29c. License number 29d, Date signed (Month, Day, Year) U.1) D-Marcus D0009215 January 29, 2004 aurence dress of person who completed cause of death (Item 23a) 7 pe, Print) Lawrence D. Marcus, M.D. 10313 Georgia Ave.

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

M. D.

31. Date filed (Month, Day, Year)

FEB 0 2 2004

Silver Spring, MD. 20902

State of Maryland / Department of Health and Mental Hygiene 2004 05314 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 29 12:30PM 2004 /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Deeth Examiner topkins 6. sex Himore HOS Johns のける 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 420-36-4914 Hours Min. Days 1**∑X** 2□ F Yrs. Director 72 Alabama Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene.

n merked other then "natural", or Itams 23e or 28e-f ehow 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madreal Examinar must be notified at Montgomery Maryland Silver Spring Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3060 Mozart Drive 20904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 TXYes 2 □ No If Yes, Give Year or Dates: unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 ▼No 3 Widowed 4 Divorced Specify: White unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Consultant Computer Technology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Norman Miller Samelia Ssacson 19a. Informant's Name/Relationship (Type, Print)
Alison Miller -daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3060 Mozart Drive Silver Spring, Maryland 20904 Health ( othar 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it eny injury or o once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metropolitan Crematory 2/1/2004 Alexandria, Virginia 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 21. Signature of Funeral Service Licensee Wandal 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) wee /Medical Due to (or as a consequence of): **Examiner** tro Denic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed nding physician and use as the burial-transit mont Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been si 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 Yes 2√ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \tag{Nursing Home} \) 5 \( \tag{Residence} \) 6 \( \tag{Other} \) (Specify) Hospital: 20 No ၉ Inpatient 1 Yes 2 ER/Outpatient 3 DOA Director: After the in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending Injury 2 Accident investigation 1 Yes 2 No Director 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 5-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MULLALLY MD Hospital 600 N Wolfe St Balto Ine HOOKINS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05315 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ETHEL G. JANUARY 28, 2004 **Physician** MOORE 12:05P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Aastoria Assisted Living Home Fulton Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Min. | July 2, 1911 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1 □ M 2√2 F Months 218-52-9675 Massachusetts 92 Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23e or 28e-1 show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Howard Fulton Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20759 11584 Scaggsville Road Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ If Yes, Give Year or Dates: Specify: Specify: White 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Moss George unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Alexander, III -P.O.A. 107 Vaquero Drive Martinsburg, West Virginia 25401 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of I 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metropolitan Crematory 1/29/2004 Alexandria, Virginia permit. Page Department of Important: If any injury or 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, P.A. Nonald Vilsa 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Congestive Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit death certificate be executed Hypertension ue to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Osteoporosis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has Lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 3E No 1 Yes Physiclan: funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 MOther Assisted Living ٩ 1 ☐ Yes 2 ☐ No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide Hospital or 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check on onel the 29b. Sign ture and title of centre 29c. License numbe 29d. Date signed (Month, Day, Year) H45839 January 29, 2004 RHTTEP! West Cedar Lane, #202A Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05316 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 25, Mangrum Jan. 2004 8:30A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton P.G. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sax 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 28 TF Days 578-50-1235 Director 67 Feb.8, 1936 N.C Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itsm 27 is marked other than "natural", or Items 23a or 28s-f show other traumatic event, the Medical Examinar must be notified at tx Yes 2 No **Funeral Director** . bM P.G. Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2111 Piermont Drive 20744 United States Race - American Ind Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 72 hours after 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7: h and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Merchandizer Private Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Guy Robert Sherrill Annie Mae Beatty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2111 Piermont Drive
Fort Washington, Md. 20744
20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If itsm 27 Is any injury or other tracence. Raymond Mangrum/husband 20744 20c. Location - City or Town, State Baltimore. 20a. Method of Disposition Pages 1 1 Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 1/30/04 Clinton, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a donsequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 25. Was case referred to medical examiner? 2 No Vital 1 ☐ Yes 2 No 1 Tyes Physician: funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 5 Pending s after death.

I Director: Af id in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MITI LIKOUL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 446 KOUL 2. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 3 2004 Registrar

DHMH 17 Rev 1/2001

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MARKELIN

State of Maryland / Department of Health and Mental Hygiene For State Registrar 05317 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JÄNÜARY 30, 2004 **Physician** BRENDA LYN MESSERSMITH 2:13P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's 220 Patuxent Road Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign
Country) **Funeral** Days Hours Min. 1□M 2√2F June 14, 1936 016-28-4561 67 Director Massachusetts Usual Residence of Decedent \*how 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov adical Exeminer must be notified at Maryland 1√ Yes 2 No Director Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 Patuxent Road 20707 United States within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White \$ 3 Widowed 4 Divorced Year or Dates: Completed The Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Dance World 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marksd Walter Lynch 2 Mary Francis Doherty Health and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai Floyd A. Messersmith -Husband 220 Patuxent Road Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National Mem. Park 2/3/2004 Laurel, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma Lung /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician ician/Medica IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 XNo Day 4☐Pregnant at time of death 5 Other (specify) P.0. detached Physic 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 XYes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Sel page 2 autopsy performed? certificate Division of Vital 1 ☐ Yes 2 🔀 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home X Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) uneral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Alter Hospital or Attending 1 XNatural 5 Pending death. investigation 1 □ Yes 2 □ No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 D19220 February 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Neil Meade, M.D. 9811 Mallard Drive, #205 Laurel, Maryland 20708 31. Date filed (Month, Day, Year) FEB 0 3 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05318 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** ETHEL MITCHELL 2004 6:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 5504 LINWOOD COURT PRINCE GEORGE's LANHAM 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Dey. 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Months Yrs. 8 Director 246-66**-**9238 14 1941 NORTH CAROLINA Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23s or 28s-f ahow the Medical Examinar must be notified at 1 Yes 2 No PRINCE GEORGE'S LANHAM Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5504 LINWOOD COURT U.S.A. Funeral 20706 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No If Yes, Give Year or Dates: Specify: Specify: BLACK ð 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER GOVERNMENT s 1 and 2 should be filed w I Heelth and Mental Hygier tem 27 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES HUNTER BRYANT of Heelth and Ment litem 27 is marked r other traumatic e LOVIE PEASALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEFFREY D. MITCHELL/SON 5504 LINWOOD CT. MANHAM, MARYLAND 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges
Department of I
Important: if ite
any Injury or of 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERAN'S CHELTENHAM, MARYLAND 2-6-2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER KOAD LANDOVER, MARYLAND 20785 -10 23a. Part1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, why one cause on each line.

METASTASIC OVARIAN CANCER Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physicien and the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No. 9 Unknown 9 ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ been sig 1 Tyes 2x No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☑ No page certificate 1 ☐ Yes 2 ☐ No rector. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 X Natural 5 Pending 1 □ Yes 2 □ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) an At new 2-2-2004 D0033482 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hanover Parkway, Greenbelt MD 20770 ,MD ieev Anand 343-A 82. Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2014 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Walter George Miller February 2004 3, 1:44 a /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Dey, Year) Aug. 28, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1XM 2□ F Director 166-14-9747 1919 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location r than "naturel", or Iteme 23a or 28e-f ehow the Medical Examiner most be notified at 10d. Inside City Limits 1 Yes 2 No Maryland | Prince George's College Park Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4711 Berwyn House Road 20740 deeth U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Valley Typesetters Truck Driver 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fi Department of Health and Mental H Importent: If Item 27 is marked oft eny injury or other treumstite even 00028. 18. Mother's Name (First, Middle, Maiden Surname) Unavailable Sarah (Unavailable) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice M. Miller - Spouse 4711 Berwyn House Road, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematory 02/05/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility Gasch's Funeral home, P.A. 21. Signature of Funeral Service Licensee Laudette Dorch مريم 4739 baltimore Avenue, Hyattsville, MD 20781 de 23a. Part1. Enter the disease, or complications that caused the death. Disect enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a AMEMORICATION CANDIONASCULUR DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown sate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cenebral 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 Natural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0018 FEBRUARY 3, ZEDY 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 W3 GUEENSBURY Rd HYATTUS 110 MD 20781 . DEVORE MA 4 31. Date filed (Month, Day, Year) 32. Registrar's Signature State A April ORIG FEB 0 5 2004

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment o rtificate	of Healt of Dea	th and M ath	He	g. No.	
	Dhamini		1. Decedent's Name (First, Middle, Las	t)					<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death
	Physicia /Medic	_	RUTH BATES McK	ENZIE					January	31, 2004	2:35 P. M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Tov	vn, or Local	tion of Death		4c. County of Deat	h
			311 Bonhi11					ashing			George's
	Funeral		5. Social Security Number 6. Se	ex 7.Aga □M2DXF	e (In yrs. last birthday) Yrs.		ays Ho	urs Min.	8. Date of Birth (Month, Day,		hplace (State or Foreign buntry)
	Director		075-18-2175 Usual Residence of Decedent		84				Aug. 27,	1919 Ne	w York
	and w	1	10a. State 10b. County		10c. City, Town or L	ocation					10d, Inside City Limits
	Mary f sh	ō	Maryland   Prince G	eorge's		Ft.	Washi	ngton			1X Yes 2 □ No
	the	Directo	10e. Street and Number			10f. Zip Co	de		10	g. Citizen of What Co	puntry?
	3a or		311 Bonhi11	Drive			207	44		United	States
	death ms 2	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent			ecify Yes or No- Rican, etc.)	14. Race - Ame	nican Indian,
٥	after or Ite		1 Never Married 2 Married	1 ☐ Yes 2 ☑ 1 If Yes, Give		1 Yes 2		ecify:			efrican merican
$\Xi$	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "naturel", or items 23a or 28a-f show event, the Madical Examiner with be notified at	Completed by	3 ₩idowed 4 □ Divorced	Year or Dates:							
'n	72 h 'natu	ete	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(GiVe	dent's Usual O kind of work d DO NOT use re	on <del>e</del> aurina	most of worki	ng 1	6b. Kind of Business	Industry
21215-0030	within ne. hen	m	Elementary/Secondary (0-12)	College (1-4or 5	i+)		,	D-1		C	
Z	iled v lygie ther t	ပိ	17. Father's Name (First, Middle, Last)	6	Dire	ector o			(First, Middle, M		nment
au	t be f ntal h ed of	Be							_	e Graham	
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene.  is marked other then 'naturel', or liems 23a or 28a-1 show is marked other then 'naturel', or liems 23a or 28a-1 show eumatic event, in	ဥ	Harry Delan 19a. Informant's Name/Relationship (1)		19b. Mail	na Address (St	reet and N	umber or Rum		City or Town, State, 2	Zip Code)
<u> </u>	d 2 s th an th an treu		Charles Foxx,						folk, VA		
ō,	tond Health tem 27 other tr		20a. Method of Disposition		20b. Place of Disp		of			Oc. Location - City or	Town, State
Baltimore,	Pages nent of I nnt: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Specify		Resurrec	•		w 2/5/	2004	Clinton	n. MD
≣	permit. Page Department Importent: If eny injury or once.		21. Signature of Funeral Service Lipen			2. Name and A				uneral Hon	-
ñ	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other treumatic evonce.		Achar T St	a Day I		400	1 Ben			Wash., DO	
			23a. Part   Enter the disease, or company shock, or heart failure. List only	plications that caused	the death. Do not en	ter the mode of	dying, suc	ch as cardiac c	r respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final		dial Infa	rction					Onset and Death Hours
	/Medical		disease or condition resulting in death)	a	a consequence of):						
	Examiner		Conventinily list conditions	b. Athero	sclerotic	Cardio	vascu	lar Dia	sease		Years
	T =	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					2.5	
	ecuter and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c							
Ö,	e execian a		resulting in deathly cast	Due to (or as	a consequence of):						
8760	licate be executed physician and s the burial-transit	dicai		d							
9	es that the death certific igned by the attending p be detached for use as	Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					23d. Date of de	ivon
Bo	attene for us	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	⊒Ectopic pregr ⊒ Other <i>(specit</i>				Month Month	Day Year
o.	he de the d	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	timo or dodan		,,				
٦.	that t ed by deta	F.	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the I	underlying caus	e given in f	Part I.	23e. Did tob	acco use contribute to	the cause of death?
Division of Vital Records, P.O. Box	Attending Physicien: The law requires that the death certific releath.  ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as		Hypertensi	on					1 🗆 Ye	s 2 1 No 3 1 Pr	obably 4 Unknown
Ö	w requir been si should	Completed	Non-insuli	n Donandar	at Diabata	- Mo11:	tuc		24a. Was an		itopsy findings available
Re	he lav	E C	NOII-THSULT	n Depender	it bladete	5 MELLI	Lus		autopsy perform	ed? death?	completion of cause of 2□ No
ß	icien: Th certificate rector, pag	ပိ	25. Was case referred to medical	-25			26.1	Place of Death	1 Yes 2	X	2 140
>	ysicie is cert direct	O B	avaminas?	Hospital:	ent 2 ER/Outpatie	nt 3 DOA	0.1			nce 6 Other (Spe	cify)
þ	ding Physicien: The Ing. After this certificate ha funeral director, page	-	27. Manner of Death	28a. Date of Inju	ry 28b. Time o		Injury at Work?		28d. Describe ho		
<u>0</u>	ath. r: Aft	atio	1 ♠ Natural 5 ☐ Pending 2 ☐ Accident investigation	1	, 100,	М	1 Tes	2 🗆 No			
<u>×</u>	Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of III	ury - At home, farm, si c. (Specify)	reet, factory, of	ffice		28f. Location (Str. City or Town,	eet and Number or Ri State)	ural Route Number,
ō	rs after all Diju	Cer		N .				- 4			
	To the Hospitel or Attenowithin 24 hours after death To the Funeral Director:	edical	(Check only 2 Medical Exar	niner: On the basis o	of my knowledge, dea f examination and/or i	th occurred at t nvestigation, in	he time, da my <i>o</i> pinion	ite and place, i, death occurr	and due to the ca ed at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To the within 2 To the Complet	Med	one)  29b. Signature and title of certifier	and manner st	ated.	29c Li	icense num	ber	29	d. Date signed (Mont	h. Dav. Year)
	To To Cor		23D. Signature and the or certifier	V		250. 5	D32		23		3, 2004
7			Of Orad	after	4	D-l-r'				TODICALY	J, 2007
)	131		30. Name and address of person who	1/			+ o = T	<i>a</i> #0.	<b>ΛΕ 17</b> 46 1	Clack MD	20744
~	- 01	ote.	H. Herbert Washi 31. Date filed (Month, Day, Year)	ngton, M. I	ar's Signature	Livings	ton K	.a., #20	Jo, Ft.	Wash., MD	20744
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 5 2004	Blown .	ar's Signature						

Physic /Medi Examir		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
/Medi						Month	Day Year	
Exami			lloy	# 05 Town	and another of Donat	February		0318 A M
	ner	4a. Fecility Name (If not institution, give stre 3600 Branch Avenue a			or Location of Death le Hills	`	4c. County of Death	
		5. Social Security Number 6. Sex	7. Age (In yrs. last birt)			8. Date of Birth		hplace (State or Foreign
Funeral Director		220-06-4876  Usual Residence of Decedent	005	rs. Months Days		8. Date of Birth (Month, Day, Y	79 Was	hington DO
72 hours after death with the Maryland natural', or items 23a or 28a-f show Assal Examiner must be resilled at	tor	10a. State MD 10b. County Prince Ge	eorges 10c. City, Town	or Location 1e Hills				10d. Inside City Limits 1X Yes 2 □ No
the	Funeral Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Co	untry?
h with	JE D	2705 Colebrooke	Drive	2074	.8	τ	JSA	
deat deat	ner	11 Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (S	pecify Yes or No-	14. Race - Amer Black, White	
ours after al', or ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No		o i noan, etc. j		1ack
72 ho	Completed	15. Decedent's Educati (Specify only highest grade co	on 16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation	king 16	6b. Kind of Business/l	Industry
within ene.	npie	Elementary/Secondary (0-12)	College {1-4or 5+}					
filed withi Hygiene. other than	Co	12th	D	rywall Fi	1	I	Building,	/Construct
s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "netural", or items 23e or 28e-f show other traumatic event, If ite Meucal Examiner must be restilled at	To Be	17. Father's Name (First, Middle, Last)  Ozell Malloy				y A. Will		
sho and l		19a. Informant's Name/Relationship (Type,		Mailing Address (Stree			-	
and and a salth n 27		Ozell MAlloy/fat		05 Colebi		The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa	e Hills	MD 20748
of He		20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Place of cemetery	Disposition (Name of r, crematory or other pla	ICO)	Date 20	c. Location - City or 1	Town, State
Peges nent of I ant: If It ury or o		*4 □ Donation 5 □ Other (Specify)	Harmo	ony Mem Pa	ark 2/7/	'04 L	andover,	Maryland
permit. Peges 1 and 2: Department of Health at Important: If Item 27 is eny injury or other trau once.		21. Signature of Funeral Service Licenses	Henry-1178	B K Hen 420 II S	ry Funer Lreet NI	al Chape	el Inc.	20002
Physician /Medical		23a. Part 1. Enter the disease, or complicate shock, or head failure. List only one commediate Cause (Final disease or condition resulting in death)	ions that caus at the death. Do no ause on each find  Head and neck  Due to (or as a consequence of	injuries	ing, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death
Examiner	L	Sequentially list conditions, b						
ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	Due to (or as a consequence o	17.				
be executed icien and burial-transi	i Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence of	f):				
eath certificate be executed attending physicien and for use as the burial-transit	Aedicai	d						
Q 00 Q	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		23d. Date of delin Month	very Day Year
ine raw requires inat ine ite has been signed by th page 2 should be detache	by	Part II. Other significant conditions contrib	uting to death but not resulting in	the underlying cause gr	ven in Part I.		cco use contribute to	the cause of death?
s been	Completed					24a. Was an	24b. Were aut	topsy findings available
10						autopsy performe Yes 2	d? death?	ompletion of cause of
Physician: this certificanal director,	Be	25. Was case referred to medical examiner?	pital:	Ott	her	th (Check only one)	min-11	7+ 0000
	. To	27 Manner of Death	I Inpatient 2 Er/Out	Datient 3 DOA	4   Nursing H	ome 5 Residence 28d. Describe how	injury occurred	ify) At scene
Attending in death. ector: After by the funer.	Certification:	1 Natural 5 Pending 2 Accident investigation	Foundation (Nay Year) In 272704 Un	known 1	rk? ]Yes 2[ <b>X</b> No	Pedestria vehicle	ın struck	
i ji ji g	Certifi	4 Homicide determined	28e. Place of Injury - At home, fare building, etc. (Specify)  Road	m, street, factory, office		City or Town, S Bonita St	State) 3600 B.  Temple	ral Route Number ranch Ave.& Hills, MD
e Hospitel 24 hours a e Funerel I etely filled	edical	29a. Certifier  Check only One  1 Certifying Physicia	an: To the best of my knowledge, On the basis of examination and and manner stated.	death occurred at the to /or investigation, in my	me, date and place opinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. Licen			. Date signed (Month	
_		3 Name ap address of person who comp	leted cause of math (Item 23a) (1		.M.E.	Fe	bruary 02	, 2004
(2)		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	44 4					
(3) st		31. Date filed (Month, Day, Year)	12. Registrar's Signature	ll Penn Str	eet, Balt	imore, Ma	ryland 21	201

DHMH 17 Rev 1/2001

ORIGINAL

Donna McBride 04-0631 AKG

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State Unpend Item	State of Ma #23a , 27 , 28	aryland / a-f per	Departme	ent of Healt are of Bea	h and Me tas	ental Hyg	giene Z	004	05322
	Physici		1. Decedent's Name (First, Middle, La	st)	^				2. Date of Dea Month		Yeer	3. Time of Death
	/Medic Examin	al -	DONNO A.  Ha. Facility Name (If not institution, give	MC K e street and number)	orido		ty, Town, or Locati	tion of Death	Janua		2004 unty of Death	9:49 A
	LAdmin		Peninsula Regiona			S	alisbury deriyear Hun	nder 24 Hrs	9. Date of Birth	Wic	comico	lace (State or Foreign
1	Funeral Director	4	5.52316=94-N41684 6.5 2/3-9/44/84	M 2/2 F 7. AS	e (In yrs. last b 36	Yrs. Month	ns Days Hou	urs Min.	8. Date of Birtl (Month, Dey	11-6	Coun	(y) VA
)	and	) <u> </u>	Usuel Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Location					11	0d. tnside City Limits
	e Mary	ctor	MD Wicc	Mico	So	2/15/2	14					1 ☐ Yes 2 1 No
	death with the Maryland ms 23e or 28a-f ahow rnast be nedfied at	Dire	10e. Street and Number 28847 Maylor	M.1101		10f.	Zip Code 2/80	01			U.S.A	
9		Fune	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces 1 Yes 2	Ever in U.S.		cedent of Hispanic pecify Cuban, Mex	c Origin? (Spec xican, Puerto F	cify Yes or No- lican, etc.)		Race - Americ Black, White, ecify:	
5-0036	72 hours after "natural", or ite	ed by	3 Widowed 4 Divorced	Year or Dates:	16	ia. Decedent's U	Isual Occupation				of Business/Inc	dustry
2		Completed	(Specify only highest gr Elementary/Secondary (0·12)	ade completed)  Cotlege (1-4or	5+)	life. DO NO	work done during ( Tuse retired)	most of workin	g	DE	ERS Y	HEAN
d 21	Hygi Hygi ther	0	17. Father's Name (First, Middle, Las	)			18. M	Nother's Name		Maiden Su	mame)	
Maryland	o d a d	To B	Johnny C. U 19a. Informant's Na. e/Relationship	VIII ans		Ob Modine Addr	ess (Street and Nu	Marg	a rest.	Bel.	) Dwn State Zin	Code)
	d 2 s th an 7 is trau		2 arry MCBri	de - Hus	bind 3	8847	NEVLOR	M,112	e-5.	1.564	g, and	21801
Baltimore,	permit. Pages 1 and Department of Healt Important: If Itam 2 any Injury or other ones.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 [	Removal from State	20b. Place	of Disposition (	Name of	į Di	ate	20c. Locat	ion - City or To	wn, State
ıltim	artmen ortant: Injury	_	4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		BYA	22. Name	and Address of F	acility	31/04	245	TVILLE	Jelishung
B	permit. Departr Imports any Inj		23a. Part1. Enter the disease, or cor	for	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa	Bunn	ie Smit	1 Lynn	al Ame	9170	ISA beile	Approximate
>	Physician /Medical Examiner		shock, or heart failure. List only tmmediate Cause (Finat disease or condition resulting in death)	a. Combined	ine.	tic (Fe	ntany1) a				ation	triterval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence							
Box 6	ne death certifi the attending thed for use as	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal dea at time of death		c pregnancy (specify)			23d	1. Date of delive Month	ery Day Year
ds, P.O	juires that the signed by ald be detact	þ	Part II. Other significent conditions	contributing to death	but not resulting	g in the underlyir	ng cause given in F	Part I.				ne cause of death?
I Records,	The law requir	Completed							24a. Was autor perfo	rmed?	death?	psy findings available mpletion of cause of 2 No
of Vital	sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner? 1∑ Yes 2 □ No	Hospital: 1 ☐ Inpat	ient WOER	Outpatient 3	Other	Place of Death  Nursing Hor			Other (Specif	v)
n of	ng Physiter this	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Ing (Month, D		b. Time of Injury	28c. Injury at Work?	2	28d. Describe			<u> </u>
Division	Attending r death.	Certification:	2 Accident investigate 3 Suicide 6 Acould not	be 28e. Place of Ir	njury - At home	known M, farm, street, far	1 Tes		Unknown 28f. Location (		PREPART PARE	y glus yunka.
Div	itel or / irs after ral Dire		4   Hornicide	Rome .	itc. (Specify)				Salisbu	ry, M	D	
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the tuneral director,	Medicai	29a. Certifier 1 Certifying f	Physician: To the bes aminer: On the basis and manners	of examination	dge, death occur and/or investiga	red at the time, da tion, in my opinion	ate and place, a n, death occurre	and due to the ed at the time,	date and pl	nd manner as s ace, and due to	tated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	11.1			29c. License num	nber		29d. Date s	signed (Month,	Dey, Year)
Į.			30. Name and address of person wh	o completed cause of	death (Item 23	a) (Type, Print)	O.C.M.E	1.0		Januai	ry 23,	2004
· _			J. LAKON W	CECIM	$\supset$	11	1 Penn S	treet,	Baltim	ore, 1	Marylan	d 21201
	St Regis	ate	31. Date filed (Month, Day, Year)  JAN 2 8 2		trar's Signature	B 4	books					

DHMH 17 Rev 1/2001

ORIGINAL

Shawn Moffett

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CILCUTT	1101		-	•
04-0,1	133	1		

Baltimore, Maryland 21215-0036

		For Unpend Item #2 Registrar  1. Decedent's Name (First, Middle,	Last)				2. Oate of Dea	ath	Year	3. Time of Death
hysici		SHAWN	VENAE		MOFFETT		Februa	ry 10,	2004	1935 P M
/Medic Examir		4a. Facility Name (If not institution,				r Location of Death		4c. County	y of Deeth	
amm		Dorchester Gene	ral Hospital		Cambrid				cheste:	
eral ctor		219-78-3993	7. Age 1 ☐ M 2 1 F	(In yrs. last birth	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da)	h, Year) -9 <b>7</b> 2		ice (State or Foreign y) 'Yland
		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10	d. Inside City Limits
event, the Mudical Examiner must be nutified at	0		rford		Ŧ	Forest F	Hill			1 ☐ Yes 2 No
	Funeral Director	10e. Street and Number	1014		10f. Zip Code			10g. Citizen of	What Counti	ry?
4	D	2359 Putnam I	Road			21050	)	Unite	d Sta	tes
	nera	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of H	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		ce - America ack, White, e	
	þ	1 ☐ Never Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  d 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	0	1 ☐ Yes 2 No			Specif	w. Whi	te
	ted	15. Decedent's (Specify only highest	Education	16a. I	Decedent's Usual Occup (Give kind of work done	pation during most of wor	kina	16b. Kind of B	Business/Indu	ustry
1	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		life. DO NOT use retire	id)				
4	Con	12	0		House	ewife	- (First Adidate		Home	
	Be	17. Father's Name (First, Middle, L.	ast)					Maidell Sullia		
	2	Thomas			Nailing Address (Street		Donna	or City of Tour		overt
		19a. Informant's Name/Relationshi								
		Robert L. Mo	fiett/Husp		Disposition (Name of	n Ra.	Date	20c. Location		21050 vn. State
or other traumatic		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 Removal from State	cemeter	y, crematory or other pla					
any injury or of once.	4	'4 ☐Donation 5 ☐ Other (Sp	ecity)	Bel Ai	r Mem. Ga	ar. 2/10	6/2004	BelAi	r, Ma	aryland
any inj	П	21. Signature of Funeral Service L	idensee	11	22. Name and Addre	ess of Facility	arretts	sville	, Mar	yland
# 9		P'III ENTERE								
		11.000	wen I way	7	E.G. Ki	urtz & S	son Fur	neral	Home,	P.A.
		23a. Pert1. Enter the disease, or o shock, or heart failure. List of	complications that caused by one cause on each line	the death. Do n	E.G. Ki	urtz & S	son Fur	neral	Home,	Approximate Interval Between
ian		shock, or heart failure. List of Immediate Cause (Final	only one cause on each im	θ.	E.G. Ku	urtz & S ing, such as cardiad	Son Fur	neral	Home,	P. A. Approximate
		shock, or heart failure. List of	Right Core	θ.	E.G. Kunnot enter the mode of dyi	urtz & S ing, such as cardiad	Son Fur	neral	Home,	Approximate Interval Between
cal		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Right Core  Due to (or as a	onary Art	E.G. Kunnot enter the mode of dyi	urtz & S ing, such as cardiad	Son Fur	neral	Home,	Approximate Interval Between
ical ner		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	a. Right Com  Due to (or as a	onary Art	E.G. Kt not enter the mode of dyi erry Dissection of):	urtz & S ing, such as cardiad	Son Fur	neral	Home,	Approximate Interval Between
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al director, page 2	Certification; To Be Completed by Physician/Medical Examiner	shock, or hear failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	A. Right Core  a. Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. Due to (or as a d. 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D  M  cobacco use con  Yes 2 \( \text{No} \)  in an psy 22 \( \text{No} \)  one idence 6 \( \text{O} \)  how injury occu  (Street and Nun  wn, State)  cause(s) and r  date and place  29d. Date sign	Date of deliver Month  Thinbute to the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the secon	Approximate Interval Batween Onset and Death  Ty Pay Year  e cause of death?  ably 4 Vinknow asy findings available pletion of cause of 2 No  I Route Number,  ated. the cause(s)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 1 9 2004



			For State Registrar	State of Maryland	/ Department of H Certificate of		tal Hygiene	2004 05324
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last ISA E EVIC 4a. Facility, Name (If not institution, give	ina Nave	dh City Town o	اا	Date of Death Month Day	3. Time of Death 3. Time of Death 5.1.1 PM
	Examin	ier	Machineton Co 5. Social Security Number 6. Sec	unty Hospit	al Hagers	If Under 24 Hrs. 8. [ Hours Min.	21756 U Date of Birth Month, Day, Year)	9. Birthplace (State or Foreign Country)
	Director		217-32-7150  Usual Residence of Decedent  10a. State  10b. County		Town or Location	l No	ov. 29, 19	34 Maryland  10d. Inside City Limits
	the Mary 28a-f eho	Director	Maryland Washin	ngton	Boonsboro		10g Citize	1 ☐ Yes 2 🔯 No
	3a or	ā	7910 Sharpsburg	Pike	2171	.3	USA	·
36	d within 72 hours after death with the Maryland liene. I than "natural", or Items 23a or 28a-f ehow The Medical Examinat must be molified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	13. Was Decedent of H	dispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No- n, etc.)	. Race - American Indian, Black, White, etc.
Maryland 21215-0036	within ane. than	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired sales cler	during most of working d)		of Business/Industry
<b>d</b> 2	Hyg II,		17. Father's Name (First, Middle, Last)	0	sales clei	18. Mother's Name (Fir.		renience store
rylan	Mental Mental arked attic ev	To Be	James Cochran  19a. Informant's Name/Relationship (Ty	rne Print)	19b. Mailing Address (Street		ilkinson	Fourth State Tim Code
Ma	and 2 sho ealth and n 27 is m		Tina Rowland - day					ort, Md. 21795
Baltimore,	0 0 = =		20a. Method of Disposition  1 ☐ Buriai 2 ☒ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State 20b. Plac	ce of Disposition (Name of netery, crematory or other place gerstown Crema	Date	20c. Loca	tion - City or Town, State
Baltir	permit. Pag Department Important: any injury conce.		21. Signatur Funeral Service Licens		22. Name and Addre		NNICH FUNE	CRAL HOME
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only of fmmediate Cause (Final disease or condition resulting in death)	cations that caused the death. ne cause on each line.				Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence).  Due to (or as a consequence).  Due to (or as a consequence).	190 cardio	al Infa	rction	
O. Box 6	the death certifi the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. if yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 Ectopic pregnancy	,	236	d. Date of delivery Month Day Year
rds, P	signed be de	þ	Part II. Other significant conditions con	ntributing to death but not resulti	ng in the underlying cause give	en in Part I.	23e. Did tobacco use	contribute to the cause of death?
Vital Records,	The law ate has b page 2 s	Completed					24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?  1 \( \text{Yes} \) 2 \( \text{L} \( \text{No} \)
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was care referred to medical examiner?	lospital:	Othi	26. Place of Death (Chi		
ō	Attending Physic death. ector: After this by the funeral di	$\vdash$	27. Mann of Death 1 Vaturaf 5 Pending 2 Accident investigation		Bb. Time of linjury 28c. Injury Work	4   Nursing Home	5 ☐ Residence 6 ☐ Describe how injury o	
Division	i Diffe	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. L	ocation (Street and N City or Town, State)	lumber or Rural Route Number,
	e Hospital 124 hours 18 Funeral 19tely filled	edical (	29a. Certifier 1 ☐ Certifying Physical Check only 2 ☐ Medical Examination	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurred at the time n and/or investigation, in my op	ne, date and place, and d pinion, death occurred at	ue to the cause(s) an the time, date and pl	d manner as stated. ace, and due to the cause(s)
)	To the within 2 To the comple	Me	29b. Signature and title of certifie	A D1	FACE P 29c. License	-78		igned (Month, Day, Year)
المر	\'Y		30. Name and address of person who co	impleted cause of death (Item 2	3a) (Type, Print)	L 11-01	25/E. AV	ary 3, 2004 stretam Street town, MD 21740
۲	Sta Registr		31. Date filed (Month: Day, Year) 20	32. Hegistrar's Signatur	saing you wan	ily Hespital	Hagers	town, MD 21170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05325 1 - For State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey **Physician** 4:00P M Harriet S. Norris February . 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Montgomery Gaithersburg If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🗓 F Yrs Sept. 1,1916 Washington DC Director 578-05-5596 Usual Residence of Decedent with the Maryland 10b Counts 10c. City. Town or Location 10d. Inside City Limits 10a. State r 28a-f ehow 1 Yes 2 No Maryland Charles Waldorf Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Evaration must be a 20601 U.S.A. 3403 Lisa Circle death 1 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces filed within 72 hours after 1 □ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: "naturel" Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Washington DC Schools Secretary other ( 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit iment of Health and Mental H lant: If item 27 is marked other. Herman Schmidt Aimee 2 Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3403 Lisa Circle Waldorf, Maryland 20601 John W. Norris (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb. 9,2004 20a. Method of Disposition Burial 2 Cremation 3 Removal from State = 5 permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Washington National Cemetery Suitland, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licensee w 6633 Old Alexandria Ferry Road Clinton, MD20735 MO0153 IN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition dementia VERS **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ģ in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Junknown 1 ☐ Yes 2 ☐ No 3 Probably Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed certificate 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident filled in by the Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and Moof certifier 29c. License number 29d. Date signed (Month, Day, Year) D.20148 February completed cause of death (Item 23a) (Type, Print) 911 N. Russell Ave, Gaithersburg, MD 20879 30. Narpe and address of person OlinsKy MD 32. Refistrar's Signature

See Special Section 1997

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month Day Y

DHMH 17 Rev 1/2001

Registrar

02

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Tung Tri Nguyen February 1, 2004 05:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Feb 2, 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1₩ 2□F 219-29-9793 81 Vietnam Director Usuat Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Directo MD Montgomery Germantown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code With 13978 Lullaby Road 20874 Vietnam 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Ite 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Asian 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Education Dept. S. Vietnam Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kiem Tri Nguyen Tuyen Thi Nguyen 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Lan Tri Nguyen - Son</u> 8045 Harbor Tree Way Gaithersburg, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or National Memorial Pk | Feb 5 2004 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer I Servi 22. Name and Address of Facility National Funeral Home 7482 Lee Hwy Falls Church, VA 22042 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Weeks Sepsis /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Weeks Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cr as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 K No 24a. Was an certificate 1∏ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Xinpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 3□ DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bao Park Terr. Germantown Executive 31. Date liled (Month, Day, Year) FEB 0 4 2004 32. Registrar's Signature State Gosell Registrar

			1 - For State Registrar	State of Maryland	d / Depa	artment of H	lealth and Death	Mental Hyg	iene 200	4 05328
A. S. C.	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last,	Nicholson		4b. City, Town, o	or Location of Dea	2. Date of Deat Month February	Day Year	3. Time of Death 7:28 A M
	Funeral Director		3918 - 23rd Par 5. Social Security Number 6. Sec 240-72-7244 Usual Residence of Decedent		as <i>t birthd</i> ay) Yrs.	Hill If Under 1 Year Months Days	crest He   If Under 24 Hrs   Hours   Min	8. Date of Birth	Year) 9. Bir	e George's thplace (State or Foreign cuntry) orth Carolina
	ne Maryland 8a-f show	Director	10a. State 10b. County Maryland Prince (	_	, Town or Lo	Hill	crest He			10d. Inside City Limits 1 X Yes 2 □ No
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Exacting Instituted at ance.	Completed by Funeral Dire	10e. Street and Number  3918 - 23rd Par  11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grad	12. Was Decedent Ever in U.: Armed Forces?  1	16a. Dece		Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	1 States  arican Indian, te, etc.  31ack
and 2121	i be filed within ntal Hygiene. ed other than " avant, I're Me	Be	Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		OO NOT use retired	ghway Wo	rker me (First, Middle, M	Govern Maiden Surname)	nent
e, Maryland	and 2 should lealth and Me m 27 is mark her traumatic	To	Robert Nichol 19a. Informant's Name/Relationship (T) James H. Burford/B	rpe. Print)				ural Route Number Dr., Clin	City or Town, State,	20735
Baltimore,	permit. Pages 1 Department of H Important: If ita any injury or otl once.		20a. Method of Disposition  1	Removal from State	metery, crer Bakers	natory or other places Cemeter Name and Addre	y 2/7	/2004	Rocky Moruneral Hor	ount, NC
	Physician		23a. Part1. Enter the disease, or complete shock of heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the death ne cause on each line.		er the mode of dyir			Vash., DC	20019 Approximate Interval Between Onset and Death
68760,	death certificate be executed  e attending physician and id for use as the burial-transit	edical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence).  Use to (or as a consequence).  Due to (or as a consequence).	ianda offi:					
P.O. Box		Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	у		23d. Date of de Month	ivery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but not resu	Ilting in the u	nderlying cause giv	ven in Part I.		s 2 No 3 P	
of Vital Records,	The ate h page	e Completed	25. Was case referred to medical				25 Place of De	24a. Was an autops perform 1 Yes 2 ath (Check only one	prior to death?	Itopsy findings available completion of cause of
	ding Phys n. After this funeral dii	atlon: To Be	examiner?	Hospital: 1  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpatient 2  Inpat	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	ner: 4 ☐ Nursing H		nce 6 Other (Spe	cify)
Division	oital or Attanours after deathers aral Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	') 			City or Town		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical		sician: To the best of my knowiner: On the basis of examinat and manner stated.			opinion, death occ	urred at the time, da		to the cause(s)
6	(3)		30. Name and address of person who co	ompleted cause of eath (Item		Print)	23743	Croophe		y 4, 2004 770
A.	Sta Regist		Martin D. We 31. Date filed (Month, Day, Year) FER 0 6 2004	2. Registrar's Signal		enway cer	ner pr.,	Greenbe	LC, FID 20	770

State of Maryland / Department of Health and Mental Hygiene 2004 05329 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** February 1, Esther Poole В. 2004 8:04P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Beverly Health Care Center Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2X F Yrs. 217-36-5164 84 30, 1920 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Gaithersburg Montgomery 10f. Zio Code 10g. Citizen of What Country? 10e, Street and Number filed within 72 hours after death with or Items 23a 101 Odenhal Avenue 20877 U.S.A. Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ₩ Widowed 4 Divorced "natural", White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5th Bookbinder Lithograph Company permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ Spencer Imogene Burdette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21791 19a. Informant's Name/Relationship (Type, Print) 12920 Copper Mine Road, Union Bridge, Maryland Frances L. Wright - Daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State \* 4 ☐ Dometico 5 ☐ Other (Specify) Bethesda Methodist Cem. 2/5/04 Damascus, Maryland 21. Signature of Fur eral Service Licensee 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home Rovert 26401 Ridge Road, Damascus, Maryland 20872-0117 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia 2 Days /Medical Due to (or as a consequence of): **Examiner** Dementia Vascular Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a co.isequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Hypertension Years Due to (or as a consequence of) Box 68760. Physician/Medical Atrial Fibrillation Years as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day jo in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 € No 3 ☐ Probably 4 ☐ Unknown Immobility Syndrone, Dysphagia, Gastritis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Depression autopsy performed? 2 🗆 No 2**7** No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 2 ☑ No this After this 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 🔀 Natural 5 Pending s after de-al Director: After 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ML D54749 February 2, 2004 30. Name and address of person who completed cause of beath (Item 23a) (Type, Print) Allen Reilly M.D. 801 Toll House Avenue - Suite Dl, Frederick, Maryland 31. Date filed (Month, Day, Year) 32. Registra Signature State 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registra 05330 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** 2332 23 Glenn Thomas Pennington, Jr. Jan. 2004 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 7600 Mathis Lane Mt. Airy Carrol1 8. Date of Birth (Month, Day, Year) Feb. 12, 1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 11X M 2∏ F 228-72-5859 54 1949 Virginia Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f show iral', or Itema 23a or 28a-f shov Examiner must be notilied at 1 ☐ Yes 2 No Directo Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7600 Mathis Lane 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1967— If Yes, Give Year or Dates: 1973 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Menial Hygiena. Important: If item 27 is marked other than "natural", or Iten eny injury or other traumatic event, the Medical Examinations. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 1973 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) J.M. Dorsey Truck Driver 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Glenn Thomas Pennington, Sr. P Grace Virginia Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7600 Mathis Lane Mt. Airy, Carole Lamb Friend MD21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lake View Mem. Park Jan. 28, 2004 Sykesville, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Burrier-Queen Funeral Directors, PA alles 1212 W. Old Liberty Road winfield, MD 21784 Part1 Enter the disease, or complications that caus a the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmortate Cause (Final is ase or condition resulting in death) Physician vears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attanding physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tensio. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 2 Heart Fail ongestive certificate 1 ☐ Yes 2 No 1 Tyes or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 Tes 2 No 2 Accident investigation the within 24 hours after deat To the Funaral Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of gertifier WIL 1)0051924 4+14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Here . entron T.MD 97 hack stor Rd Man his er MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Alexa St figerly

JAN 3 0 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Yeer Physician Willie Peterson 9:20a M Jr. 01 28 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☑ M 2 🗆 F 84 12-15-1919 Director 577-28-1815 South Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f ahow traumatic avant, the Madical Exerciner must be notified at 1⊈Yes 2 □ No Director Prince Georges Capital Heights 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number "natural", or Itema 23a or 5021 Addison Rd. USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Itam 27 ia merked other than "na any injury or other traumatic avant, Ita Madic one. Elementary/Secondary (0-12) College (1-4or 5+) Private Cook 7th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Willie Peterson Sr. 2 Rosa Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Peterson/ Wife 5021 Addison Rd., Capital Heights,MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cem. 02/04/2004 Brentwood, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) Yes 2 No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. infec 1 Yes 2 No 3 Probably Unknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Martner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. ineral Director: A filled in by the Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier death (Item 23a) (Type, Print) State Registrar

			1 = For State Registrer	State of Marylan	d / Depa <i>Cei</i>	artment rtificate	of He	ealth and Death		giene Reg. No		4 05	332
	Dhysisi	_	1. Decedent's Name (First, Middle, Last)						2. Date of Dea		y Year	3. Time of I	
	Physicia /Medic	al		EL					JANUAR'		2004 County of Dea	10:5	M A8
	Examin	er	4a. Fecility Name (If not institution, give str.  Laurel Regional H				own, or i	Location of Dea	เท	40.		··· George	1
	Famoust		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year	If Under 24 Hr		h Vacal		thplace (State or buntry)	
	Funeral Director			4 2□F 5	0 Yrs.	Months	Days	Hours Mir	Dec.31	, 195	3 Sou	ith Caro	lina
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	eation						10d. Inside Cit	
	shov	ă				oallon						1 TyYes	
	28a-f	rect	Maryland Prince Ge	orge's Lau	пет	10f. Zip C	Code			10g. Cit	izen of What Co	ountry?	
	3a or	0	14114 Bowsprit Lane	, #912		207	707			Un	ited St	ates	
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturs!, or Items 23s or 28s-f show svent, I're Medical Examiner must be traffiled at	Funeral Directo	11. Marital Status	. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decede	ent of His	panic Origin? ( , Mexican, Pue	Specify Yes or Norto Rican, etc.)	-	14. Race - Ame Black, Whit		
ð	or ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 □ Yes 2		Specify:			Specify:	White	e
9500-91212	turs!',	q pe	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educa	Year or Dates:	16a Dece	dent's Usual	Occupat	tion		16b. K	ind of Business		
ς Υ	in 72 n "ne n	Completed	(Specify only highest grade of	completed)	(Give	kind of work DO NOT use	done du	iring most of w	orking			,	
717	filed within Hygiene. other than " snt, the Me	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Compu	ter Sp	ecia	alist		Loc	kheed-M	artin	
	al Hyg	Bec	17. Father's Name (First, Middle, Last)		_			18. Mother's Na Elizab	me (First, Middle,	Maiden	Sumame)		
<u>X</u>		10	Philip Samuel Peel			_							
Maryland	2 2 2 2		19a. Informant's Name/Relationship (Type Kristen E. Peel –Da		1				Rural Route Numbe				
	1 and Health em 27 othar tr		20a. Method of Disposition		Place of Dispo cemetery, crea	sition (Name	e of	K CTICIO	e Columbi		Mary Lan ocation - City or		
no.	Pages nent of I int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ref 4 ☐ Donation 5 ☐ Other (Specify)	noval from State					31/2004	77		***	
altimore,	permit. Pag Department Important: I any Injury c	1	21. Signature of Funeral Service Licensee		10p011	2. Name and	Address	of Facility	dt Funera	ATE	xanoria	, virgir	11.3
ä	Depa Impo any i	10	1 Canald V. Bo	quaret	_ D	400 Pc	v. i wdei	c Mill 1	Rd. Belts	u He	ome, P. le. Mar	A. vland 20	1705
	<u> </u>		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ons that caused the deat cause on each line.	h. Do not en	er the mode	of dying	, such as cardi	ac or respiratory ar	rest,	,	Approximate Interval Betw	een veen
	rnysician	'n	Immediate Cause (Final disease or condition	Seizure Di	sorder							Onset and D	reaut
je.	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):								
B	LABITITIES	70	Sequentially list conditions, if any, leading to immediate	Renal Fail	ure uence of):							-	
	ted nsit	Examiner	cause. Enter Underlying										
Ţ	execu n and ial-tra	Exar	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):								
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edicai	d.										
89	ntifica ng ph	Medi	IF FEMALE:										
Вох	eath certific attending p I for use as i	Physician/M	23b. Was decedent pregnant in the past 12 months?	<ul> <li>If yes, outcome of pregnant</li> <li>1 ☐ Live birth 2 ☐ Feta</li> </ul>	I death 3	Ectopic pre					23d. Date of de Month	,	'ear
0	the a	/sici	1 Yes 2 No	4☐ Pregnant at time of d 9☐ Unknown	leath 5	Other (spe	ecify)			+			
٥.	uires that the de signed by the a Id be detached f		Part II. Other significant conditions conti	ributing to death but not res	sulting in the u	nderlying ca	use give	n in Part I.	23e. Did to	obacco	use contribute t	o the cause of de	eath?
Records,	uires sign	d by							101	Yes 2	<b>X</b> No 3□P	robabiy 4 🗀 U	inknown
00	w require been sign	lete							24a. Was			utopsy findings a	
	The lav te has age 2	Completed							autop perfo 1 ☐ Yes	osy irmed? 2 X No	death?	completion of ca	tuse ot
Vital		Be C	25. Was case referred to medical examiner?				_	26. Place of D	eath (Check only o				
<u>_</u>	Physicisn: r this certific ral director,	Tof	1 Yes 2 XNo	spital: 12 Inpatient 2	ER/Outpatie		-	4   Nursing	Home 5 ☐ Resid	dence	6 ☐Other (Spe	ecify)	
Division of		on:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		Bc. Injury Work		28d. Describe I	how inju	ry occurred		
Sio	Attending ir death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm st	M soot factory		es 2 □No	28f Location (	Stroot ar	ad Number or R	ural Route Numb	her
$\leq$		Certification:	4 Homicide determined	building, etc. (Special		reet, ractory,	OHICE		City or Tov			57G. 77GGG 77G7712	,
hear	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in			cian: To the best of my kno									
	To the Hospital within 24 hours To the Funeral completely filled	edical		er: On the basis of examina and manner stated									(
	To th within To th comp	M	29b. Signature and the of certifier	1 1/1/11/		29c.	License D10				te signed (Mon	-	0.4
•			> Jul	Lav III			D19	ZZU			January	30, 20	U <b>4</b>
2	(0)		30. Name and address of person who com Neil A. Meade, M.I	npleted cause of death (Iter	п 23а) (Туре	Print)							
	0		31. Date filed (Month, Day, Year)	9811 Malla		ve La	urel	, Maryl	and 20708	3			
	Sta Regist		FFR 0 3 2004	Mark - K	Some	11							

			1 - State Registrar	te of Maryland		artment <i>tificate</i>				iene <sub>99. No.</sub> 20 (	04 05333
	Physicia	an	Decedent's Name (First, Middle, Last)  The Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Process of the Pro						2. Date of Deat Month Feb.	1 <sup>Day</sup> 2004	3. Time of Death
	/Medic Examin		Beatrice T. Powers  4a. Facility Name (If not institution, give street a	and number)		4b. City. T	own, or Loc	ation of Death		4c. County of E	
	Examin	CI	5806 Lawton Court	,			nham			Darings	Georges
Ī	Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Months		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Aug. 10	Year) 9.	Birthplace (State or Foreign Country) Virginia
	p.		Usual Residence of Decedent			1			1	,	
	ehow	7	MD 10b. County Prince Geor		Town or Lo						10d. Inside City Limits
	28a-f	Director	10e. Street and Number	ges	Lan	10f. Zip C	Pode		1	0g. Citizen of Wha	1 ☐ Yes 2 No
	3a or	ā	5806 Lawton Court			207				U. S. A	
	death	Funeral	11. Marital Status 12. Wa	s Decedent Ever in U.S.	13. V			nic Origin? (Sp	pecify Yes or No- Rican, etc.)	14. Race - A	American Indian,
õ	or Ite		1 Never Married 2 Married 1 If Y	ned Forces? ]Yes 2X]No 'es, Give		res,spec⊪ I∐ Yes 2∭		exican, Puerto pecify:	Hican, etc.)	Specify: ]	Vhite, etc.
2-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow digal Examiliar must be notified at	ed by	3X_Xvidowed 4 □ Divorced Ye	ar or Dates:			,				
2	e filed within 72 hours after death with the Marylan al Hygiene. I other than "natural", or tlems 23a or 28a-f ehow vent, the Madical Examinat must be multified at	Completed	15. Decedent's Education (Specify only highest grade comp	oleted)	(Give	lent's Usual kind of work DO NOT use	done durin retired)	g most of work	king	16b. Kind of Busine	ess/Industry
717	d within giene. er than	E O	Elementary/Secondary (0-12) Coi	ltege (1-4or 5+)	Fact	ory Wo	rker		F	ood Proce	essing
and	be filed tal Hygi d other event, t	Be	17. Father's Name (First, Middle, Last)						e (First, Middle, M		<b>—</b>
5		10	Casper Taylor					atrice		4	
Z	d 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 an		19a. Informant's Name/Relationship ( <i>Typ</i> e, <i>Pri</i> John Powers – son	nt)					dywine,	City or Town, Star	te, Zip Code)
	ges 1 and to Ges 1 and to Ges 1 and 1 item 2 or other		20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name	of			20c. Location - City	or Town, State
saltimore,	Pages nent of int: If it iry or o		1 \( \overline{\text{Burial}} \) Burial 2 \( \overline{\text{Cremation}} \) Cremation 3 \( \overline{\text{Remova}} \) Remova	irrom State		emeter		Feb.	7. 2004	Suffolk	r VA
<u></u>	permit. Pag Department Important: I any Injury o		21. Signatura of Funeral Service Licensed	haces	22	. Name and	Address of	Facility	Bell Fun	eral Home	e, P. A.
נו	2029		yuaiyagi ya	11 ISON						le Hills,	MD 20748 Approximate
	Physician /Medical Examiner	ner	Sequentially list conditions. b. —	Due to (or as a consequence)	nce of):	ie C	and	woo	sula	1 chois	Interval Batween Onset and Death
8/00,	certificate be executed ding physician and use as the burial-transit	dical Examiner	that initiated events	Due to (or as a conseque	nce of):			T-00-10-10-10-10-10-10-10-10-10-10-10-10-			
õ	ndificate ng phys as the	Medi	IF FEMALE:								
.O. BOX	death e atter	Physician/Me	23b. Was decedent pregnant in the past 12 months?	es, outcome of pregnanc ]Live birth 2 ☐ Fetel di ]Pregnant at time of deal ]Unknown	eath 3	Ectopic preg Other (spec				23d. Date of Month	delivery Day Year
λ, T	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions contribution	ng to death but not resulti	ing in the un	derlying cau	ise given in	Part	23e. Did tob	acco use contribut	e to the cause of death?
ora	equire	ted	Iglabeles In		2)1	Jal	lim	nelle	1 ☐ Ye	s 2121No 3□	Probably 4 Unknown
Zec Zec	The la ate has page 2	Completed	Shore						24a. Was an autopsy perform	24b. Were prior death	autopsy findings available to completion of cause of 1? Yes 2 12 No
N Z	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					Place of Deat	h (Check only one		
0	Physi this c	1.	1 ☐ Yes 2 ☑ No Hospital  27. Mann of Death 28a.	1 Inpatient 2 EF	VOutpatient			☐ Nursing Ho		nce 6 Other (S	Specify)
_	f or Attending Physician: after death. Director: After this certification by the funeral director.	cation	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury	M 200	Work?	2 🗆 No	28d. Describe hor	w injury occurred	
	To the Hospitel or Attendir within 24 hours after death.  To the Funerel Director: At completely filled in by the fu	Certification:	4 Homicide determined 286.	Place of Injury - At home building, etc. (Specify)					City or Town,	State)	Rural Route Number,
	ne Hosp 24 hou ne Fune bletely fil	edical	29a. Certifier 1 Certifying Physician: (Check only one) 2 Medicel Examiner: Or an	To the best of my knowle the basis of examination d manner stated.	edge, death n and/or inv	occurred at estigation, in	the time, da n my opinion	ate and place, n. death occur	and due to the car red at the time, da	use(s) and manner te and place, and c	as stated. due to the cause(s)
	To ti Veithii To ti comp	ğ	29b. Signature and title of certifier	1 ( ), ()	4 4 4 4	29c. I	License nun	nber	29	d. Date signed (Me	onth. Day, Year)
/	(5)		30. Name and address of person who complete	d cause of death (Item 2	3a) (Type, I	Print)	) 1 (	+10	1 0	01110	7
	Sta	te	31. Date filed (Month, Day, Year)	1 Y) DO  2. Registrar's Signatur	Au	tht		Suit	land	and ?	-9750F
	Registr		FEB 0 4 2004	lien &	boss	K)					

State of Maryland / Department of Health and Mental Hygiene 014 05334 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ROMULO MUNAR **OUINTOS** JANUARY 29, 2004 11:40P. /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth **Examiner** Renaissance Gardens Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Aug. 26, 1931 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**7** M 2□ F Phillipines 564-56-4624 72 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c, City, Town or Location in then "netural", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2X No Maryland Montgomery Silver Spring Direct 10g, Citizen of What Country? 10e. Street and Number 10f, Zip Code 3116 Gracefield Rd., #207 20904 United States death 1 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1文 Yes 2 No
If Yes, Give Year or Dates: 1958-19 Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: if item 27 is marked other then "netural", or iter eny injury or other traumatic event, the Medical Examinat 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: 1958-1978 Asian Ď 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) United States Chief Petty Officer NAVY 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Ouintos Mercedes Santiago 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emedita E. Quintos -Wife 3116 Gracefield Rd., #207 Silver Spring, Md.20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Arlington National Cem. 2/10/2004 Arlington, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 21. Signature of Funeral Service Licensee yonald U Borg 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease Physician 1 year /Medical Due to (or as a consequence of): **Examiner** Pneumonia 2 months Sequentially list conditions, if any, leading to immediate the first inverting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 5 autopsy performe 1 ☐ Yes 2 ☐ No certificate 1∐ Yes 2XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P 1 ☐ Yes 2 ☐ No SIL 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: After 5 Pending investigation 1 Xatural М 1 □ Yes 2 □ No death. 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral E Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 humana, MD February 2, 2004 059524 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Loveen Puthumana, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904 2. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 0 3 2004 State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Amended \$25,27,28a-fperME FCDertificate of Death KS 2/5/04 Reg. No. 2004 2. Date of Death 1. Decedent's Name (First, Middle, Last) 19 2004 **Physician** Mildred Mary Ruby January 6:00 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Aug. 19, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 82 Yrs 1921 Maryland 215-14-1323 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic avant, the Medical Examiner must be notified at 1.□Yes 2□No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21703 U.S.A. 5771 Box Elder Court or Items 23a Completed by Funeral illed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 3 Widowed 4 □ Divorced White natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Customer Service 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If tem 27 is marked othe any injury or other traumatic avant. 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Ira Jacob Basler Rose Lowe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 29, Newcomb, Maryland 21653 Michael E. Ruby (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 24 Cremation 3 Removal from State Smithsburg, Maryland Smithsburg Crematory 1/20/04 \* 4 ☐ Donation 5 ☐ Other (Specify) ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, o shock, or hear failure. List eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (F **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dias to for as a nonsequence of Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown į Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No page 10-23 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical miner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 25 No In atient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 10-23-2003 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending IO A M 1 ☐ Yes 2 🛣 No Fell at home 2 Accident investigation within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence 28f. Location (Street and Number or Rural Route Number, 4 - Homicide 5771 Box Elder Ct. Frederick, M. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and itie MARYKAW no completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso House Teltukch Jethusch CVALU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

			Please Type or Print in Black I  State of Maryland / De  1- State Registrar  C	ndelible Ink. Ensure partment of Health and ertificate of Death	Mental Hygi	ene <mark>2004</mark> 05336
,	Physici /Medi	cal	Decedent's Name (First, Middle, Last)     Rick Alan Reed		2. Date of Death Month	Day Yeer 500 AM
	Examir	er	4a. Facility Name (If not institution, give street and number) 10726 Timothy Drive	4b. City, Town, or Location of Dea Williamsport		Washington
1	Funeral Director		5. Social Security Number 219-60-4401 6. Sex 7. Age (In yrs. last birthda 51 Yrs.	y) If Under 1 Year If Under 24 Hr Months Days Hours Mir		
	e Maryland 3a-f show tiffied at	ctor	10a. State 10b. County 10c. City, Town or Maryland Washington William			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with the	al Directo	10e. Street and Number 10726 Timothy Drive	10f. Zip Code 21795	10	g. Citizen of What Country?
036	ilied within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itema 23a or 28a-1 show ont, tra Musical Exartiral must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amped Forces? 1972— 1 Never Married 2 Married 1 Never Married 2 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 2 Never Married 1 Never Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Marri	3. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue 1  Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 ho iene. r than "natu	Completed	(Specify only nignest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	edent's Usual Occupation ve kind of work done during most of wo DONOT use retired) Dort Technician	C	6b. Kind of Business/Industry Communication Equip. anufacturer
Maryland 21	d a b	Be	17. Father's Name (First, Middle, Last)		me (First, Middle, M.	
Z	should be nd Mental marked o	J.	Charles Donald Reed  19a. Informant's Name/Relationship (Type, Print)  19b. Ma	Lois Vi	irginia Ki	
	s 1 and 2 should f Health and Mer tem 27 ta marke other traumatic		Teresa L. Barron/Sister 106	32 Honeyfield Road		sport, MD 21795
saitimore,				position (Name of ematory or other place) awn Mem. Park 02-0	_	Oc. Location - City or Town, State agerstown, Mary Land
Rail	permit. Pege Depertment of Important: If any Injury or once.			22. Name and Address of Facility Os 425 S.Conococheagu	sborne Fun ue St. Wi	eral Home,P.A. Iliamsport,MD 21795
	Physician /Medical Examiner	-	23a. Part: Enter the disease, or complications that caused the death. Do not e shock, or heart faiture. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as e consequence of):  Sequentially list conditions,	nter the mode of dying, such as cardia		Approximate Interval Between Onset and Death  Y ,no n /h,
,00/00	certificate be executed ding physicien and ise as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):			
. DOX	atter for u	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
ecolds, r	requires that the neen signed by th hould be detache	ρχ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?  2 1 10 3 Probably 4 Unknown
פט	The law ate has b page 2 s	Completed			24a. Was an autopsy performe	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Oth	ath (Check only one)	
DIVISION OF	To the Hospital or Attending Physician: A thin 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	$\vdash$	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury	4 Nursing P	28d. Describe how	ee 6 ⊡Other (Specify) injury occurred
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
	e Hospi 24 hou e Funer letely fill	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal of the basis of examination and/or is and manner stated.	th occurred at the time, date and place ovestigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
		×	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)
	351		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		2.5.04
			30. Name and address of person who completed cause of death (Item 23a) (Type Michel O-Micometic IIII)  31. Date filed (Month, Day, Year)  FEB 0 6 2004  32. Registrar's Signature	o medici la	mus 10	Eserbua Mo
	Sta Registra		FEB 0 6 2004 Segurar S Signature	alle!		

ORIGINAL

			1 - For State Registrar	State of Maryland	l / Depa <i>Cer</i>	rtment of tificate o	Health and f Death	Mental Hyg	giene 200	4 05337
<i>)</i>	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last)	RUTH ANN ROW		4b. City, Town	or Location of Dea	2. Date of Dea Month JAN . 3		3. Time of Death 2:10 A M
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Ia M 2√2 F 5.4		If Under 1 Year Months Day	r If Under 24 Hrs	8. Date of Birth	Year) 9. Bir	thplace (State or Foreign ountry)
	be tiled within 72 hours atter death with the Maryland ital Hygiene. id other than "natural", or itams 23a or 28a-f show other than "natural", or itams 23a or 28a-f show event. The Madical Examiner must be notified at	Funeral Director	10a. State 10b. County MD. CARROLL 10e. Street and Number 943 RUBY DR.		Town or Loc	NSTER  10f. Zip Code 2115		1	0g. Citizen of What Co	10d. Inside City Limits 1 \( \overline{A}\) Yes 2 \( \overline{N}\) No puntry?
5-0036	hours atter deati tural', or itams 2	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	1	Yes, specify Cu □ Yes 2X N		to Rican, etc.)		e, etc. ITE
2121	tiled within Hygiene. ther than " int. the Ma	e Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)  1 2  17. Father's Name (First, Middle, Last)	ation completed) College (1-4or 5+)	(Give i life. D		e during most of wo	rking me (First, Middle, I	16b. Kind of Business  EDUCATIO  Maiden Sumame)	
Maryland	2 should be and Mental is marked o raumatic eve	~	KENNI  19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin		CHRIS	STENE	KILBY	
a,	Pages 1 and 2 should beont of Health and Ments int: If Itam 27 is marked iry or other traumatic e		RONALD E. ROWLES  20a. Method of Disposition  12 Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)	20b. Pla	ice of Dispos	sition (Name of	(ace)	Date	R, MD. 21 20c Location - City or FINKSBUR	Town, State
Balti	permit. Pag Department important: h any injury o		21. Signature of Funeral Pervice License	tch-f.	25	4 E. M	AIN ST.	WESTMI	FUNERAL INSTER, M	D. 21157
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	m Bi			c or respiratory arre	951,	Approximate Interval Between Onset and Death
eu,	be executed iclan and burial-transit	Ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a conseque		7-791-6				
O. Box b	The law requires that the death certificate te has been signed by the attending physoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnand  1 Live birth 2 Fetal of  4 Pregnant at time of deal  9 Unknown	leath 3 🗍	Ectopic pregnan Other (specify)	су		23d. Date of del Month	ivery Day Year
ecords, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions cont	ributing to death but not result	_				es 2 No 3 Pr	
		e Completed	25. Was case referred to medical				26 Blace of Do	24a. Was ar autops perform 1 Yes 2	y prior to death?  No 1 □ Yes	topsy findings available completion of cause of
n or	ng Phys fter this ineral dii	Certification: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 Ei  28a. Date of Injury (Month, Day Year)	R/Outpatient 28b. Time of Injury	28c. Inj	ther: 4 🗌 Nursing H		nce 6 Other (Spec	sify)
Š	spital or Att		3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)  Cian: To the best of my knowledge.	10-			City or Town		
	To the Hospital or Attandi within 24 hours after death. • To the Funeral Director: A completely filled in by the to	Medical	(Check only 2 Medicel Examine one)  29b. Signature and title of certifier	er: On the basis of examination and manner stated.	on and/or invi	estigation, in my 29c. Licer	opinion, death occu	urred at the time, da	ite and place, and due  Od. Date signed (Month	to the cause(s)
,	W30		30. Name and address of person who com STEPHEN SIKORSK			rint)	3592 DD WEG		2/2/04	4.5.7
ı	Sta Registr	te ar	31. Date filed (Month, Day, Year) FEB 0 2 20	1 , MD 912 32. Registrar's Signatu	NADUI	Sall.	KIJ., WES	TRITING LEF	R, MD. 21	15/

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Dey 28 Year 11:15 17 **Physician** ) Anherry 2004 Irving Carl Rader /Medical 4b. City, Town, or Location of Deeth c. County of Death Fecility Neme (If not institution, give street end number, Examiner Anna Armde or H Calen mol 2 VVVVn 8. Date of Birth (Month, Day, Year) Aug. 27, 1940 if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Wash., D.C. 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex **Funeral** Months Hours 10 M 2□ F 63 Director 217-42-8167 Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Be Completed by Funeral Director Millersville Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 534 Old Mill Road 21108 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 NYes 2 No If Yes, Give 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1966–68 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Defense Contractor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Oris Lester Rader Verena Cecil Wilson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 534 01d Mill Road Charlotte A. Rader / spouse Millersville, MD. 21108 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State Lakemont Mem. Gardens 2-2-2004 Davidsonville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Beall Funeral Home 6512 NW Crain Highway Bowie, MD. 20715 23a. Pert1. Enter the Jisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner SR for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Vital Records, P.O. Box 68760, Due to (of as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? TSres 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings 24a. Was an autopsy Be Completed available prior to completion of cause of death? 1 You 2 100 1 ☐ Yes 2 No certificata 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No inpatient 2 ER/Outpetient 3 DOA edicai Certification: To this 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation † Naturel 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours \*\*Certifying Physicisn: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier To the Hosp within 24 ho To the Fund completely fi 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2001 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) V O 31. Date filed (Month, Day, Year) 2. Registrer's Signature State FEB 0 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05339 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Dav Boyce Richmond January 8:22 p /Medical 2004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton If Under 1 Year Prince Georges If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1¥ M 2□ F 59 Director 331-36-5203 28, 1944 Chicago, Usual Residence of Decedent 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director XXYes 2 No Maryland Prince Georges District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 United States 2103 Brewton Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1≱Yes 2 □ No 9/15/63 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc filed within 72 hours after 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates: 10/31/83 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Assistant Chief of Appeals Government Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fittenent of Health and Mental Hitam 27 Is marked ott Be 2 Richmond Rosalie Giles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 Is any injury or other trau Wanda Richmond / Spouse 2103 Brewton Street District Heights, Md. 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State Feb. 11,2004 Arlington, Va. Arlington National 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22 Name and Address of Facility ope Funeral Homes Part lEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike/Forestville, Md. 20747 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Know /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner as a consequence of) the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Haknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 1 Yes 2 No f or Attending Physician: after death. Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Limpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Hatural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SILVERSPRIM ND 20902 6 Pon AVE Suit 31. Date filed Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

DHMH 17 Rev 1/2001

P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05340 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 01/30/2004 Lonnie **Physician** Richardson, Jr. 11:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pineview Nursing Home Clinton Prince George's If Under 1 Year Months Days 8. Date of Birth (Month, Day, Y 10/20/21 5. Sociel Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign Country) North Carolina 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1,□,M 2□ F Months Director 245-18-1539 Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Its Madical Examinal must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George Oxon Hill 1 ☐ Yes XXNo Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7901 Esther Drive 20745 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1XXYes 2 □ No WWII If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black à Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tile Setter 5 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Manley Lonnie Richardson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) n-law 7901 Esther Drive Oxon Hill, Md. 20745

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Total Ellerson Spurlock, III/Son-in-law 20a. Method of Disposition 20c. Location - City or Town, State MXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 2/4/2004 Cheltenham.MD. 22. Name and Address of Facility
George P. Kalas Funeral Home PO.A. 21. Signature Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Part I. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Covonary Av Tery Disease Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and I for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificent conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Minknown UZSCUL Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours e 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

29c. License number

1328 SouThern

29d. Date signed (Month, Day, Year) 01-30-04

AUR SE-DC

Division of Vital Records, P.O. Box 68760

Registrar

29b. Signature and title of certifier

21 me

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 2 2004

BolelLo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2 1 14 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2 Day Month 2004 9:18 am **Physician** DeAngelo Antonio Ross /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Prince Georges Cheverly Prince Georges Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-30-1982 9. Birthplece (State or Foreign 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Louisiana 21 Yrs. 215-31-8134 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County rsi', or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Glenarden Prince Georges Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20706 USA 8403 Hamlin St. #102 Funerai death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Item any injury or other traumatic avant, the Madical Examine 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 2 X No 1 X Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Cotlege (1-4or 5+) Etementary/Secondary (0-12) NONE Unemployed 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Angela Paden Alexander L. Ross 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8403 Hamlin St. #102, Glenarden, MD Angela Ross/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-2-2004 Washington, DC Mt. Olivet Cemetery <sup>4</sup> □ Donation 5 □ Other (Specify) 21. Signature of Furrera) Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final ardiac arrest **Physician** disease or condition resulting in death) /Medical Examiner - vedtick 3 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Spina use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □ Ectopic pregnancy Month Day Year for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached o 9 Unknown 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes You No 24a. Was an mea/ 2.XNo 1 Yes Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 1 ☐ Yes 2 X No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 28/04 1)48152 30. Name and address of person who completed Jause of death (ttem 23a) (Type, Print) Samuel Semegn M. D. 1221 Mercantile Lane Largo, Maryland 20774 31. Date filed (Month, Day, Year) State 0 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05342 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 26 2004 Isabelle 9:44 PM Ross /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 8807 Crandall Road Lanham 7. Age (In yrs. last birthday)
79 Yrs. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 250 Months Days Hours Min. 18 Director 1924 VIRGÍNIA 579**-**34-4251 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f ahow or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20706 8807 Crandall Road or Itams 23a Completed by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify. BLACK 3 XWidowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY GOVERNMENT 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if of Health and Menta ANNIE MAE MCCAWLEY WILBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1717 TERRAPIN HILL MITCHELLVILLE, MARYLAND 20721 DIANNE ROSS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 2/2/2004 Rockville, Maryland Parklawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SUDDEN CARDIAC DEATH **Physician** /Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner DIABÉTES MELLITUS or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physicien Physician/Medicai the for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 ☐ Yes 1 Tyes 2√ No 2 X No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death | Check on one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death 2 Accident investigation 1 ☐ Yes 2 ☐ No the 1 within 24 hours after deat To the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) D13443 Hansen MI Day 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1145 19th Street N.W. # 210 Washington, DC 20036 DARCEY HANSEN M.D. 31. Date filed (Month, Day, Year 32. Registrar's Signature State FEB 0 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05343 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 2,2004 **Physician** ELIZABETH C. ROBERTSON 9:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months 1 M 2 XF 67 579-56-8444 September 24,1936 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits in then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 AYes 2 No Director Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 1656 40th Street, S.E 20020 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contract Supervisor U.S. Gov't permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Itam 27 is marked oth eny injury or other traumatic event 20xe. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alexander Reddick Gertrude Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 Kings Tree Drive, Mitchellville, MD 20721 Alex, Reddick/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem. 02/05/2004 Suitland, MD <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Figneral Service License 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave. Suitland, MD 20746 at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENCEPHALOPATHY **Physician** /Medical Due to (or as a consequence of): CEREBRAL ANOXIA Examiner 2 marthi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Cher (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ MELLITUS 1 Yes 2 No 3 Probably 4 nown Completed ATHEROSCLERETIC CARDIOVASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Popatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Peath lilled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 MPendina death. 2 Accident investigation 1 □ Yes 2 □ No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital within 24 hours a To the Funeral completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 200 (co/5/10) 29c. License number 29d. Date signed (Month, Day, Year) D050545 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GODEWILL O 7513 New Hampshire Avenue Takma Parke 31. Date filed (Month, Day, Year) State Registrar

-	Physici	an	1 - State WiCHD, dq Registrar Amend #231  1. Decedent's Name (First, Middle	, 02-02-04 , Last)	, PerP	ну Се	runcate	of Hea	alth and eath	Mental Hy  2. Date of De	Reg. No.	0 0 4 Year	3. Time of Death
	/Medic Examir	al	MARGUERITTE  4a. Facility Name (If not institution ATLANTIC GENERA	, give street and nu		RC	ARTY  4b. City, Too  BER		cation of Dea	ath	1	nty of Death	310 P M
2	Funeral Director		5. Social Security Number 272-07-6130  Usual Residence of Decedent	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs	: last birthday) Yrs.	If Under 1 Y		Under 24 Hr fours Mir		1,1909	9. Birth Cou Ker	place (State or Foreign ntry) Tucky
o o o o	the Maryland 28e-f ehow	ctor	10a. State 10b. County	ester		ity, Town or Lo Ocean F							10d. Inside City Limits 1 □ Yes 2 ☑ No
6130	death with the Maryland ms 23a or 28e-f ehow rmst ter nylllied at	Funeral Director	10e. Street and Number 1135 Ocean Pa					1811			10g. Citizen	A	
07-61	ifter its	b	11. Marital Status  1 □ Never Married 2 □ Marri  3 ※ Widowed 4 □ Divorced	Armed Fo	2. Mo ve		was Deceden If Yes, specify  1 ☐ Yes 2  X		inic Origin? ( Mexican, Pue Specify:	Specify Yes or No irto Rican, etc.)	Spe	Race - Ameri Black, White, cify: W	
1215-0	filed within 72 hc Hygiene. ther then "natur ent, the Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 1.2	's Education t grade completed) College (		(Give	dent's Usual C kind of work of DO NOT use r	done duri retired)	n ng most of w	orking		Business/In	,
Jand 2	e d la be	To Be Co	17. Father's Name (First, Middle, Lonnie Shiel			1 HOII	епакег			ame (First, Middle Sherron		nestic	
SS H	and 2 shi ealth and n 27 le m		19a. Informant's Name/Relationsl Dennis M. Roar		200		Wharf	Cou		Rural Route Numb ean Pine	s, MD :	21811	
Courty	Page nent o ant: If ury or		20a. Method of Disposition  1  Burial 2  Commation  4  Donation 5  Other (S)  21. Signature of Funeral Service	pecify)	State	cemetery, cre lisbur	matory or other y Crema	r place) atory		26/04		bury,	MD
<u>\$</u>	permit. Departr Importe eny inji		2 a. Part I. Enter the disease, or thock, or heart failure. List	complications that	aused the dea		501 S	now 1	HIII K	d., Sall	sbury,	ional MD 2 <u>1</u>	Association 804 Approximate Interval Between
•	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	- a - P/	10	quence of):		516	Tio				Onset and Death 2 dzys
015180	To the Hospital or Attending Physicien; The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conse								
6 O. Box 68760	the death certific y the attending p ched for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oirth 2 ☐ Fei nant at time of	tal death 3[	⊒Ectopic pregr ⊒ Other <i>(speci</i> i					Date of delive Month	ery Day Year
	w requires that the d been signed by the should be detached	þ	Part II. Other significant condition	ons contributing to d	leath but not re	sulting in the u	nderlying caus	se given i	n Part I.	23e. Did t	_/		he cause of death? pably 4 [Unknown
Division of Vital Records	: The law requ cate has been page 2 shoul	Completed								24a. Was autop perfo 1 ☐ Yes	an 24l	prior to co death?	ppsy findings available impletion of cause of 2 No
Ž.	rsicien; Th s certificate director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Inpatient 2	⊒ ER/Outpatie	nt 3 DOA	Othor		eath (Check only of Home 5 Residue)		Other (Specif	(v)
ion of	tranding Physicien; The death.  ctor: After this certificate h, y the funeral director, page		27. Manner of Death 1 ☐ Natural 5 ☐ Pendin 2 ☐ Accident investig	28a. Date g (Mon gation	of Injury oth, Day Year)	28b. Time o Injury		Injury at Work?	2 □ No	28d. Describe			,,
Divio	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Certification:	3 Suicide 6 Could in determine	ined 286. Place build	of Injury - At ing, etc. (Spec	ify)				City or To	vn, State)		al Route Number,
	o the Hosi ithin 24 ho o the Fund ompletely f	Medical	29a. Certifier (Check only one) 1 ✓ Certifyin 2 → Medicel 20b. Signature and title of certifier	-	a best of my kr pasis of examir iner stated.	nation and/or in	vestigation, in	my opini	on, death occ	curred at the time,	cause(s) and date and plac 29d. Date sig	e, and due to	o the cause(s)
	5		30. Name and address of person	who completed caus	se of death (Me	ghy 3 om 23ay (Type,	Print)	14	428	73	1/3	14/0	4
41	∆ Sta		31. Date filed (Month, Day, Year)	32. F	Registrar's Sign	733 nature	Hez/	The	-24	Drie	<u> </u>	ele	MO
	Regist	rar	FEB 0	2 2004	Serer	a B	Apo	aks	/		- 5111		

ORIGINAL

			For State Amended#26pe:	State of Maryland / Deprend FCHD, KS2/5/06	partment of Health and Nertificate of Death	Mental Hyg	giene 100 4 0 0 4	05345
			Decedent's Name (First, Middle, Last)			2. Date of Dea	ith	3. Time of Death
	Physicia		Alice Cathe	rine Scigliano		Jan.	22, 2004	3:10 P.M
	/Medic Examin		4a. Fecility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Death	<del></del>	4c. County of Death	
			Kline Hospice	House	Mt. Airy		Freder	ick
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	// If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	r, Yeer) Cou	plece (Stete or Foreign ntry)
	Director		220-48-6495 1 1 Usual Residence of Decedent	M 2M F 80 Yrs.		July		MD
	and w		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Mary f sho	ច្ច	MD Fred	erick Myer	sville			1 ☐ Yes 2X No
	r 28a	Director	10e, Street and Number		10f. Zip Code		10g. Citizen of What Cou	intry?
	h with		2320 Michael	l Rd.	21773		USA	
	deat	Пег	11. Marital Status	Was Decedent Ever in U.S. 13     Armed Forces?	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
9	or its	by Funeral	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	•	Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Modical Examinar mast be notified at		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:	edent's Usual Occupation	1	16b. Kind of Business/Ir	
15	in 72 "na" r	Set	(Specify only highest grade	completed) (Gir	re kind of work done during most of work DO NOT use retired)	king	Tob. Talle of Bealings	iodotty
77	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	omemaker		own home	9
פַ	e filed at Hygie other vent, the	BeC	17. Father's Name (First, Middle, Last)				Maiden Sumame)	
/lar	should be and Mental s marked c umatic ev	ToE	Grover F. H	orine	Annie	Palme	r	
Maryland		1	19a. Informant's Name/Relationship (Type		iling Address (Street and Number or Ru			
	Health Health tem 27		John Scigliano		O Michael Rd.,	Myersv:	ille, MD :	
Baltimore,	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		position (Name of Trend of 1/29			
ij	t. Pa rtmen rtant: njury		' 4 □ Donation 5 □ Other (Specify)		dist Cemetery		Myersvil:	le, MD
Bal	permit. Pages Department of Important: If is any injury or once		21. Signatury of Fun ral Service License	MARTINES	Donald B. Thomp	son Fu	neral Home	9
			23a Part1. Enter the disease, or complic	ations that caused the death. Do not e	31 E. Main St., nter the mode of dying, such as cardiac	or respiratory are	etown, MD	21769 Approximate
	-		Immediate Seuse Final	e cause on each line.	ic Scloren	-		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	a scenos			4 years
	Examiner		b b					
-	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
	ecute and trans	Examin	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
8760,	ate be executed only sicial and the burial-transit		, , , , , , , , , , , , , , , , , , , ,	Due to (or as a consequence or).				
687	phys phys s the	edical	d					
Box (	death certificate be executed e attending physician and nd for use as the burial-transi	N/Me	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of pregnancy	.D-		23d. Date of deliv	rery
	death e atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death	□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.0	t the by th ache	hys	9 ☐ Unknown	9 Unknown				
S, F	res tha igned l	by F	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	2	bacco use contribute to	
brd	w requires been sign should be	ted	Meuman	a certanuo	, hepinagous	1□Y	es 2 □ No 3 □ Pro	bably 4 Unknown
of Vital Record	aw Is b	Completed	Super Chal	es vero Cemi	1 deffuse	24a. Was e autop perfor	sy prior to co	opsy findings available ompletion of cause of
E	Th ate pag	Š	Boulmon	iary Kill	20065		med? death? 2 □ NO 1 □ Yes	2□ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Wa ase referred to medical examiner?	ospital:	Other	th (Check only or		Hospice
of	Phys r this ral dii	. To	1 ☐ Yes 2/☐ No	1 Inpatient 2 EH/Outpat	of 28c. Injury at	ome 5 Describe h	lence 6-4⊵40ther (Speci low injury occurred	<sub>fy)</sub> Hospice
on	ding f h. After funer	tlon	1 Inatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury			. ,	
Division	Attending ir death. ector: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm,	street, factory, office	28f. Location (S City or Tow	Street and Number or Run	al Route Number,
ă	al or Att s after do il Direct ad in by t	Certification:	4 Homicide	building, etc." (Specify)		Chy of 10w	n, State)	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by			icien: To the best of my knowledge, deter: On the basis of examination and/or				
	To the H within 24 To the F complete	Medical	one)	and manner stated.	29c. License number		29d. Date signed (Month,	
	To To	-	29b. Signature and Otle of certifier	Manhall .	200. Liverise indition	23 1		2 2 -
	$\circ$		MAN	rypleted eause of death (Item 23a) Typ	() () 55 / 8	5	1 elma	ng > 2004
	9		30. Name and address of person who co	At CON KTOL	200 W 9th	Fre	derick	mo
	Sta	ite	31. Date filed (Month, Dey, Year)	32. Registrat's Signature	1		7	
	Registi		FEB 05	2004 Den 5	Sporte			

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 03

32. Registar's Signature

State of Maryland / Department of Health and Mental Hygiene 05347 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2, Month February **Physician** RUSSELL CLEVELAND STANG 2004 6:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F **Funeral** 220-28-3154 85 Director Usual Residence of Decedent 10c. City, Town or Location Show 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23e or 28e-f show any injury or other traumatic avent, the Medical Examiner must be notified at once. 1 Yes 2 No Director Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6513 Mountaindale Road 21788 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Luther Stang Annie Summers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Stang (Wife) 6513 Mountaindale Road, Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Prospect Cemetery 2/6/04 \* 4 ☐ Donation 5 ☐ Other (Specify) Lewistown, Maryland 21. Signature of Funeral Service Liganiste ROBERT E. DAILEY & SON FUNERAL HOMES, P. 615 EAST MAIN STREET, THURMONT, MD 21788 Kent 23a. Part1. Enter the disease, or complications that caused the deth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CONGUSTIVE HOHRT KAILURG VEGETS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, the attending physician use as the IF FEMALE: 23c. If yes, out*co*me of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ٥ in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown ERIPHORIL VASCULAR DISCUSS 24b. Were autopsy findings available prior to completion of cause of death? ROWAL FAILUDE autopsy performed? 1 Yes 2 No 1 Yes 2 🗷 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital pellij Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only To the ! 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D35171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Box 328 R. GOUGH PU WALKORSVILLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 5 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 05348 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Bonnie Bernice Steinhaus February 2:53 PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 West Orndorff Drive Brunswick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 21 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 213-40-3061 61 Vrs Director 1942 Frederick, MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. Count 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Evanmer must be notified at MD 11 Yes 2 □ No Frederick Brunswick Director 10f. Zip Code 10e, Street and Number 10g, Citizen of What Country? 6 West Orndorff Drive 21716 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Call, Frederick MD LPN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked ott Stanley F. Boyer Dorothy Lowe Boyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deirdre J. May, Daughter 1603 Thomas Drive, Point of Rocks, MD 21777 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ŏ 1 

Burial 2 

Cremation 3 

Removal from State Department o Important: If any injury or once. St. Luke's Cemetery 12/7/2004 Feagaville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licens Williams 22. Name and Address of Facility Barbara A. Williams, Owner John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician metastate c Misson 0000c /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate class. For any long class (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical the 88 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 🗌 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies completely filled in by the funeral director, to 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 ANatural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25 MD 0056590 04 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIFIE OM ISWANDE DUNGER Gessert 610 CM 31. Date filed (Month, Day, Year) 32. Regitrar's Signature State Registrar FEB 0 5 2004

( )	ERIO		1 - For Unpend ITem#2	State o 3a,PartII,2	f Marylan 7 <b>,28a f,</b> P	d/Depa	artment of H 379,3723/04 fificate of L	ealth and <i>Seath</i>	Mental Hyg	giene 200	4 05349
			Decedent's Name (First, Middle						2. Date of Dea	ath	3. Time of Death
	Physici /Media	_	Mark Vale Ser	io					Februa	ry 05, 200	15:25 M
	Examir		4a. Facility Name (If not institution, Bon Secours Ho		m <i>ber)</i>		4b. City, Town, or Baltim		ath	4c. County of De	ath
	Funeral Director		5. Social Security Number 217–08–8530	6. Sex 12 M 2 ☐ F	7. Age (In yrs. 36	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		(, Year) (	irthplace (State or Foreign Country) MD
	and W		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	e Maryla Sa-f aho	ctor		Arundel			Severna P	ark			1 ☐ Yes 2√∑ No
	3a or 28	i Dire	10e. Street and Number 611 Westmorela	nd Place			10f. Zip Code	21146		10g. Citizen of What (	Country? JSA
920	be filed within 72 hours after death with the Maryland hal Hygiene. ad other than "natural", or items 23e or 28e-f ahow avent, the Mckitral Exercises relative troubled.	by Funeral Director	11. Marital Status  1 X Never Married 2 Marri 3 Widowed 4 Divorced	Armed Fo	2 <b>[X</b> ]No ∕e		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? ( n, Mexican, Pue Specity:	Specify Yes or No- irto Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White
21215-0036	within 72 ho iene. r than "natur itie Wedical.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, Disabl	uring most of w	orking	16b. Kind of Busines	s/Industry
Maryland 2	12 should be filed withir h and Mental Hygiene. 7 is marked other than traumatic avant, Ille Ma	Be	17. Father's Name (First, Middle, I	_ast)					ame (First, Middle, n Monning		
ΙΖ	Should od Me merk matic	T <sub>o</sub>	19a. Informant's Name/Relationsl	sip (Type, Print)		19b. Mailir	ng Address (Street a			r, City or Town, State,	Zip Code)
	s 1 and 2 should f Health and Men item 27 is merks other traumatic		Lillian C. Ser	io/Mother		Alberta State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State Stat		and Plac	-	na Park, M	
Baltimore,	6 = 5		20a. Method of Disposition  1 XBurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Othey (St		C	emetery, cren	sition (Name of natory or other place st Cemete:	ry Fel	b. 10, 2004	20c. Location - City of Annapolis	
Balt	permit. Par Department Important: any injury		21. Signature of Funeral Service	icensee	1/2	B 4	Name and Address AFFANCO & 95 GOV. R	Sons, itchie	P.A. Seve Hwy, Seve	rna Park F rna Park,	Tuneral Home MD 21146
P			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on e	ach line.	h. Do not ent	er the mode of dying				Approximate Interval Between Onset and Death
	Physician /Medical	į.	Immediate Cause (Final disease or condition resulting in death)	a	bronchops (or as a conseq						
	Examiner	Ja	Sequentially list conditions,	b. Due to	(or as a conseq	uence of):					
	scuted and transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	,						
8760,	icate be executed physician and s the burial-transit	ledical Ex	rooding in oddin, cast	d.	(or as a conseq	uence or);					
.O. Box 68	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live b	tcome of pregna pirth 2 ☐ Feta nant at time of d	I death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
<u>α</u>	quires that n signed build be deta	by	Part II. Other significant condition Seizure disorder,				nderlying cause give	n in Part I.	23e. Did to	1	to the cause of death?  Probably 4 □Unknown
I Records,	The law ate has b page 2 s	Completed							24a. Was a autops perform	sy prior to	
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Otho		eath (Check only or	76)	
of	Phys this ral dii	: To	1X Yes 2 No 27. Manner of Death	28a. Date	-	ER/Outpatien 28b. Time of		4 Li Nuising		ence 6 Other (Sp ow injury occurred	ecify)
ion	Attending I ir death. ector: After by the funer	atior	1 □Natural 5 □Pending 2 □ Accident investig	(Mon	th, Day Year)	Injury <b>Eound 2:</b>	28c. Injury Work	? ′es 2. <b>x</b> No	unknown	, ,	
Division	D in the	Certification:	3 ☐ Suicide 6 🕱 Could r 4 ☐ Homicide determi	ot be 28e. Place	of Injury - At ho	ome, farm, str	eet, factory, office		28f. Location (S. City or Town	treet and Number or F n. State) I <b>yson St.,Bal</b>	
_	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical C		g Physician: To the Examiner: On the ba	best of my kno asis of examina				e, and due to the c	ause(s) and manner a late and place, and du	as stated.
	To the To the Comple	Med	29b. Signature and title of certifier	and mani	ner stated.		29c. License	number	2	9d. Date signed (Mor	oth, Day, Year)
	->-0		Jaster R	Green	sen	MD	0.	C.M.E.	F	February 0	6, 2004
			30. Name and address of person Jasha Z Gine	who completed caus	se of death (Item			eet, Ba	ltimore,	Maryland :	21201
	Sta Registi		31. Date filed (Month, Day, Year)		egistrar's Signa	ature					

State of Maryland / Department of Health and Mental Hygiene 2004 05350 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last). 2 Date of Death Physician Feb. <sup>2</sup>2004 8, 06:55 AM MARY PAULINE SMITH /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Somerset Marion Station 3905 Shelltown Road 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month 8Day 3 Year) 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Days Hours 215-38-1561 64 Director Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director MD Somerset Marion Station 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21838 USA 3905 Shelltown Road Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Itams 23, any or other traumatic avent, the Modical Examinan must 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Specify.White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rosie Popkins 2 Charles L. Sims 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Hammond Smith, Jr. 3905 Shelltown Rd., Marion Sta., MD 21838 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: if any injury or once. Rehobeth Cem. 2/11/2004 Rehobeth, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fyneral Service Licensee 22. Name and Address of FacilityHolloway Melson Funeral Home ADean MD 21851 103 Linden Ave., Pocomoke City, 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on and line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): I or Attending Physician: The law requires that the death certificate be executed that cleath.

Director: Alter this certificate has been signed by the attending physician and in by the thundard director, page 2 should be detached for use as the burlat-transit in by the fundard director, page 2 should be detached for use as the burlat-transit. resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕱 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 😿 No Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 □ Yes 2 □ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ny Day, Year)
B 1 1 2004 31. Date filed (Month, State Registrar's Signature Registrar

			1 - State Registrar			nd / Depa		t of H	ealth and Death	•	Hygie		2001	0535
	Dhomini		1. Decedent's Name (First, Middle, L.	ast)						2. Date Mont	of Death	Day	Year	3. Time of Death
	Physici: /Medic		ROBERT ALC							2		4	2004	1109 <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, gi Atlantic General					Town, or erlin	Location of Dea	th			ounty of Death orceste	
	Funeral		5. Social Security Number 6.	Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 24 Hrs	s. 8. Date	of Birth			place (State or Foreign
5	Director		201-26-5074	1 <b>X</b> M 2□F	68	Yrs.	Months	Days	Hours Min	5/9	of Birth th Day Y 193!	ear)	Cour	PA PA
007	and W		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						1	10d. Inside City Limits
P002/40/2	Maryli f sho	tor	MD Worce	ster		Ocean								1 XYes 2 □ No
702	within 72 hours after death with the Maryland ene. Than "netural", or Items 23a or 28e-f show ha Nedical Ezairi act nuat be trolified at	Funeral Director	10e. Street and Number				10f. Zip	Code			10g	. Citize	n of What Cour	ntry?
60	ath wil	rai D	715 Twin					2184				US		
23	er de	nne	11. Marital Status 1 □ Never Married 2 Married	12. Was Dec Armed Fo 1 XYes	edent Ever in U proes?	I.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes rto Rican, et	or No- c.)	14.	. Race - Americ Black, White,	
5/04/1935	urs aft	þ	3 Widowed 4 Divorced	If Yes, Gir Year or D	ve		1 ☐ Yes	2 <b>X</b> ) No	Specify:			S	pecify: Wh	ite
5/09/1	72 ho	Completed	15. Decedent's 8 (Specify only highest gi			16a. Dece	dent's Usua kind of wo	al Occupa	ation furing most of wo	orkina	16	b. Kind	of Business/In-	dustry
121	l within 7. liene. r than "n	mpi	Elementary/Secondary (0-12)	College (	1-4or 5+)							Т.,		Co
A U	filed Hygi ther int, I		17. Father's Name (First, Middle, Las			Corp	orate	ACC	t. Direc		liddle, Ma		lephone <sup>(mame)</sup>	Co.
-	ed at a s	To Be	Herbert Slotter	•					Edna	Henry	/			
Robert -5074 Maryland	and and is m	Г	19a. Informant's Name/Relationship	(Type, Print)					and Number or R					Code)
· · · <del></del>	1 and 3 Health lem 27 other tr		Jane Slotter		20h 1				ee RD (	Ocean	-			
10 P	0 0		20a. Method of Disposition  W☐ Burial 2 ☐ Cremation 3			Place of Disponentery, crea			nes 2/7				tion - City or To	
	된 <b>원 년</b> .		<ul> <li>4 □ Donation 5 □ Other (Spec</li> <li>21. Signature of Funeral Service Lice</li> </ul>		Ga				1				n Pines	
S C	permit. Departn Importe any injt		Y Tomusline	1 Bah	bete	1	08 W	illian	The St. Be	Burb erlin	age   MD	Fun 218	eral Ho 311	me
			27a. Part1. Enter the disease, or shock, or he failure. List on	plications that	aused the dear								B-B-E-E-E	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a me	tastati	000	schae	zeal	Can	cer				Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):								
		er	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consec	quence of):	<u>ر</u>							
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· Pul	Mon	ary e	amo	lisn	$\wedge$					
760,	be executed sician and burial-transit		resulting in death) Last	Due to	(or as a consec	juence of):								
	m 2 m	dical		d										
× 6	certifi nding se as	√Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn							230	d. Date of delive	erv
. Box	death e atter	Physician/Med	in the past 12 months?	4□Pregr	oirth 2 ☐ Feta nant at time of c		□Ectopic pr □ Other <i>(sp</i>						Month	Day Year
P.O.	at the by th	hys	9 🗆 Unknown	9□ Unkn			-					<u> </u>		
s, l	res tha	ρ	Part II. Other significant conditions	contributing to d	eath but not res	sulting in the u	inderlying c	ause give	en in Part I.	23e.	Did tobac			he cause of death?
oro	requi	eted								045	<del>-</del>			
of Vital Records,	ne taw s has l ge 2 s	Completed									Was an autopsy performe	d2	prior to cor death?	psy findings available mpletion of cause of
酉	en: Ti tificate tor, pa	ø	25. Was case referred to medical		/				26. Place of De		res 2 🗆	No	1 🗌 Yes	2 No
Ξ	ysicio lis cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🔀	Inpatient 2	ER/Outpatier	nt 3 DC	Othe	\c			e 6 [	Other (Specify	y)
0 =	ng Ph tter th ineral		27. Manne Death 1 atural 5 Pending	28a, Date (Mon	of Injury th, Day Year)	28b. Time o Injury		8c. Injury Work		28d. Des	cribe how	injury o	ccurred	
Division	ttendi death. stor: A	ertification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	De Geo Blace	of Injury - At h	ome farm str	M reet factor		/es 2□No	28f Loca	tion (Stree	at and N	lumber or Bura	al Route Number,
Div	after after Direct	ertif	4 Homicide determine	build	ing, etc. (Speci	fy)	reat, lactory	, onlo			or Town, S		tambor or riara	Thousand,
	To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	edical C	29a. Certifier 1 : Certifyin 7 (Check only one) 2 ☐ Medic Exe	miner: On the b	e best of my kno easis of examina ner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my or	e, date and place pinion, death occ	e, and due to	the caus	se(s) an	d manner as st ace, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier					. License			29d	Date s	igned (Month,	Day, Year)
			· // //	mo	)			D5	3612		á	2/4	104	
OH	, 4+1		30. Name and address of person who	-	se of death (Iter	n 23a) (Type.	Print)	0/1	hway	D. K	Berli	. 1	MO	21811
0.11	Sta	te	/ NICH CEC /		Registrar's Sign	ature	140	011	(VVII)	101	erll	7	1-10	01011
	Registr		31. Date filed (Month, Day, Year)	004	eur 1	K So	adi							

State of Maryland / Department of Health and Mental Hygiene 2 10 1 05352 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year **Physician** Ам FEBRUARY 4:40 2004 Lillian Myrtle SOUDERS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1□M 2XF Yrs. April 16,1916 87 Director 212-38-7859 Maryland Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a. State 28e-f show be filed within 72 hours after death with the Maryla nat Hygiene.

Attal Hygiene.

And other than "natural, or Iteme 23a or 28e-1 show of the than "natural, or Iteme 23a or 28e-1 show wast, the Madical Examinar must be natillised. 1 ☐ Yes 2 ☐ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10913 Roessner Avenue 21740 Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 ☐ No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Nurse Private Duty 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event 2008. Be ပ Jim Douglas Lucy LeFever 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard Souders - Son 17607 Woodlawn Drive Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/4/04 Rest Haven Cemetery Hagerstown, Maryland 2. Name and Address of Facility Minnich Funeral Home 21. Signature of Euneral Service Licens 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bilature **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner eleluo. yos u Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): -burial-Box 68760, the attending physician Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year for Day 4☐Pregnant at time of death 5 Other (specify) P.O. funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 Yes 2 No 3 Probably Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1□ Yes 🔊 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatrent 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📆 No Certification: To this o Manner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Attending 1 Natural 2 Accident 5 Pending Division 1 ☐ Yes 2 ☐ No death. investigation the Director 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after ŏ Hospitel within 24 hours a 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Maul 2-2-04 D28365 PH 30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Struct Hagerstain 170-2/740 HAR 68 mills 31. Date filed (Month 32. Pagistrar's Signature State

Registrar

SOUDERS.

State of Maryland / Department of Health and Mental Hygiene 2004 05353 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year SOUDERS **Physician** Karen Diane 1:10 # M kinuary 31 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington County Hospital Hagerstown Washing Pen \* | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 21, 1957 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F 46 Yrs. 217-88-016 West Virginia Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ral', or Items 23a or 28a-f show Examiner must be notified at 1 TYes 25 No Maryland Washington Sharpsburg Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18561 Burnside Bridge Road 21782 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic avent, the Medical Evaluarian page. Black, White, etc. 1 Never Married 21X Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) none profit 0 - 12care provider 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ray T. Norris Lynda DeLauney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18561 Burnside Bridge Road, Sharpsburg, Maryland John N. Souders 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Memorial 3 3, 2004 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 Trid L.V MAIN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cul /Medical Due to (or as a consequence of): **Examiner** Perosmolar Diabelic Non-Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Hypovolaemia and burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, nding physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 1 Yes 2 No detached 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, sign. þ 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No 1 Yes 2 No 1 Tyes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 3 DOA 70 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification; After the Hospital or Attending 1 Natural 5 Pending investigation after death.

Director: All d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060396 6 1126 Opal Court Hagerstum Marylano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHED AKID MUR MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of M	arylan		artmen rtificate					Reg. No.	2004	0535	4
	Physici /Medic		1. Decedent's Name (First, Middle, La Irene	Gertrude	SCHR	OYER					Date of De Month	Day	2004	3. Time of Death	M
	Examin		4e. Fecility Name (If not institution, give Washington Count					Town, or a	Location o	of Death	(		ounty of Death shingt		
	Funeral Director		5. Social Security Number 6. S		e (In yrs. I	ast birthday) 83 Yrs.	If Under Months		If Under a	Min.	Date of Birt (Month, Da Ct. 10	h		plece (State or Fore intry) yland	ign
	e Maryland ta-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Washing	;ton		,Town or Lo								10d. Inside City Lim	
	3a or 28	I Dire	10e. Street and Number 826 Pine Street				10f. Zip		1740				U.S.A.	intry?	
030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Examiner must be notified at ODGe.	by Funeral Director	11. Marital Status  1 Never Married 2 A Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	,		Was Deced If Yes, spec		panic Orig , Mexican Specify:	gin? (Specif i, Puerto Ric	ly Yes or No can, etc.)	1	Race - Amer Black, White pecify: Wh	, etc.	
212-0036	rithin 72 ho	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or:	5+)	(Give life.		rk done di se retired)	tion uring most	t of working			of Business/I		
yland 2	d be filed wantal Hygier ced other to	Be	0-7  17. Father's Name (First, Middle, Last  Roma Lu	0 other Shar	nk		homen		18. Mothe	·	First, Middle,	Maiden Si	r own l umame) line De		
Mary	12 shoul h and Me 7 Is mark resumati	2	19a. Informant's Name/Relationship (	(Type, Print)			-			ar or Rural P		ar. City or 1	Town, State, Z		
nore, i	ages 1 and of Healt it if Item 2:		20a. Method of Disposition 1 23 Burial 2 Cremation 3	Removal from State		lace of Disponentery, cremetery, cremetery	natory or o	ne of ther place		Date Februa	eary	20c. Loca	ition - City or 1	own, State	
Baitimore,	permit. Pa Departme Importent any injury once.		* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		1	22	2. Name an	d Address			nich :	Funer	al Home	Maryland earyland 21	7/10
/b0,	Physician /Medical Examiner physician and physician and the printle physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and th	dical Examiner	shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence a consequence	uence of):	<u> </u>							Interval Between Onset and Death	
O. Box 68	it the death certificate by the attending phys tached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	death 3	⊒Ectopic pr ⊒ Other (sp					23	d. Date of deli-	very Day Year	
ords, P.	The law requires that the tite has been signed by th bage 2 should be detache		Part II. Other significent conditions	contributing to death b	out not res	ulting in the u	nderlying c	ause give	n in Part I.		101	Yes 2	No 30 Pro	the cause of death?	wn
Vital Records,		e Completed	25. Was case referred to medical						00 81	(D) 11 (	1 ☐ Yes	med?	24b. Were aut prior to c death? 1 \( \sum Yes	opsy findings availa ompletion of cause of	ole of
ō	ding Phy h. After this funeral d	To B	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5  Pending 2  Accident investigation	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	ury	ER/Outpatier 28b. Time o Injury		8c. Injury Work	r: 4 🗆 Nu	rsing Home	Check only on 5 ☐ Resident of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of the house of	dence 6 [	Other (Spec	ify)	
Division	ie Hospitel or Attend 124 hours after death ie Funerel Director: bletely filled in by the	Certification:	3 Suicide 6 Could not be determined		jury - At ho tc. <i>(Specif</i> )	ome, farm, str	reet, factory	, office		281	f. Location (S City or Tov		Number or Ru	ral Route Number,	
	ne Hospi n 24 hou he Funer pletely fil	edical	29a. Certifier  (Check only 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	of examina tated.	tion and/or in	vestigation	, in my op	inion, dea	th occurred	at the time,	date and p	nd manner as lace, and due	stated. to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1			290	License	number			2/1/6	signed (Month	, Day, Year)	
S. S.	Y		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)	1.0.	-10	1	") / ~	767	·		
9	Sta Regist		31. Date filed (Month Par Year)	completed cause of CZL	rar's Signa	ture	on the	way		c, and	, 041	126			

nysicia		1 - For Amend Item #1 Registrar  1. Decedent's Name (First, Middle, Last					2. Date of Deat Month	th	3. Time of Death
Medic		Ernest Golden Sl	hetron				72 bruer	Day Year	107:14 M
xamin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Deet	th
		Washington County 5. Social Security Number 6. Se		yrs. last birthday)	Hagers If Under 1 Year		8. Date of Birth	Washin	
neral ector			X M 2□ F	73 Yrs.	Months Days	Hours Min.	(Month, Day, August		thplace (State or Foreign buntry)
.010.		Usual Residence of Decedent					August .	2/ 1930 M	aryland
other traumatic event, the Michael Examiner must be notified at	_	10a. State 10b. County	10c.	. City, Town or Lo	ocation				10d. Inside City Limits 1X Yes 2 □ No
office	Director	Maryland Washin	igton	Hagerst			1	Og. Citizen of What Co	
T P	급	10e. Street and Number			10f. Zip Code 21740		,		ouriu y ?
	Funeral	712 Guilford Ave	12. Was Decedent Ever i	n U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp.	ecify Yes or No-	USA 14. Race - Ame	
	by Fun	1 Never Married 2 Married 3 Widowed 4 NDivorced	Armed Forces?  1 **TYes 2 ** No If **Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Puerto	Rican, etc.)	Black, White Specify: Wh	e, etc. nite
		15. Decedent's Edi		16a. Dece	dent's Usual Occup	pation during most of work	ina	16b. Kind of Business/	'Industry
	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	,,,,g		
		12		Paint	er	10 Mathada Nami		Self-emplo	yed
7. 19	Be	17. Father's Name (First, Middle, Last)  Roy M. Shetron				18. Mother's Name	izabeth		
	ဥ		vpe. Print)	19b. Maili	na Address (Street			, City or Town, State, 2	Zip Code)
		19a. Informant's Name/Relationship (T. Marla B. Teach, D. Martha B. Teach	aughter					m, Md. 217	
		20a. Method of Disposition	20		esition (Name of matory or other place			20c. Location - City or	
		1 X Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify,	nemoval mom State	Rest Hav	en Cemete	ery 2/5/2		Hagerstown	, Maryland
DDCe.		21. Signature of Juneral Service Licens	900					Funeral Ch	
a	_	7.11							Md. 21742
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.	leath. Do not ent	er the mode of dyir	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
n al		Immediate Cause (Final disease or condition resulting in death)	a. Kec	tal (	anch				1/2 yr
er er			Due to (or as a con	sequence of):					
	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con	saquence of).					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.						
		resulting in death) Last	Due to (or as a con	sequence of);					
	lica		d						
	Physician/Medical	IF FEMALE:	23c. If yes, outcome of pre	agnancy				22d Data of doll	i na
	clan	in the past 12 months?	1 Live birth 2 □ F	etel death 3	Ectopic pregnancy Other (specify)	у		23d. Date of deli Month	Day Year
2000	nysi	1  Yes 2  No 9  Unknown	9☐ Unknown						
	by	Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
	Completed						24a. Was ar	n 24b. Were au	topsy findings available
	ш						autops	y prior to death?	completion of cause of
	a	25. Was case referred to medical				26. Place of Death		No 1 Yes	2 No
	To B	examiner? 1  Yes 2 No	Hospital: 1 Inpatient	2  ER/Outpatier	nt 3 DOA Oth			ince 6 Other (Spec	cify)
		27. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c, Injur Wor	ry at rk?	28d. Describe ho	w injury occurred	
	catic	2 Accident investigation				Yes 2 □ No			
	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, larm, str ecify)	eet, factory, office		28I. Location (Str City or Town	reet and Number or Ru i, State)	iral Route Number,
a in by the tune	9	29a, Certifier 17 Certifying Phy	ysician: To the best of my	knowledge, deat	h occurred at the tir vestigation, in my o	me, date and place, opinion, death occurr	and due to the ca red at the time, da	iuse(s) and manner as ate and place, and due	stated.
stely filled in by the fune		(Check only 2 Medical Exam	and manner stated						
	Medical Ce	(Check only 2 Medical Exam	and manner stated.		29c. Licens	se number	29	9d. Date signed (Month	
	edical	(Check only 2 Medical Exam	and manner stated.	MA	29c. Licens	se number	29		h, Day, Year)
completely filled in by the	edical	(Check only 2 Medical Exam	and manner stated.	L MO	) D	41667	29	9d. Date signed (Month	h, Day, Year)
completely filled in by the funer	edical	29b. Signature and title of certifier	and manner stated.	L MO	) D	41667	Hag.		h, Day, Year)

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 05356 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month Dev Violet Mae SNECKENBERGER February 3, 2004 5:05 a.m. /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Julia Manor Nursing Home Hagerstown Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🖺 F Yrs. 214-09-4207 88 Director Feb. 3, 1916 Maryland Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or item a 28 or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 620 Northern Avenue 21742 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: Š white 3 ☐ Widowed 4 X Divorced Yeer or Dates: Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) parts expediter aircraft 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John A. Sneckenberger Mary Ann Herbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21795 Helen Needy - niece 14241 Box Q Falling Waters Rd., Williamsport, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 2/4/04 Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licenses 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760. Due to (or es e consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown þ director, page 2 should be Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificata has 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Yes, 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completaly filled in by the funeral 27. Menny of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 aturel 5 Pending investigation aftar death. Director: Aft 1 ☐ Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) cause of death (Item 23e) (Type, Print) 11110 31. Dete filed (Mon Yea () strer's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1- State Amend Item 23a, PtI per Dr., G828, 02/25/Odd Milicate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** David Crowdy Scrivener JAN 2004 6: SEAM 14 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ARUNDEL ANNE NORTH ARENDEL HESPITAL GIEN BURNIE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 16, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 12 M 2□ F Yrs. 1941 62 Maryland Director 215-38-3256 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28e-f show 1 XYes 2 No Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ă 1746 Circle Rd., #301 21144 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status STREET, filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No The Medical Exam Black þ Specify: 3 ☐ Widowed 4 ☑ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Disability None event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil timent of Health and Mental H tant: If Item 27 is marked oth jury or other traumatic even Estelle Crowdy Richard Scrivener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Ann Phinn - Sister 1501 S. George Mason Dr., #01, Arlington, VA 22204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department important: If any injury or once. Lee's Crematory Clinton, MD 1/25/2004 21. Signature Funeral Service Licensee Stewart Funeral Home 22. Name and Address of Facility 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death (DP) - Chronic Obstructive Pulmonary Disease **Physician** /Medical Due to (or as a consequence of): **Examiner** in Suchrit Dehydrahan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed dyest and Due to (or as a consequence of) physician a s the burial-1 Box 68760. ALCOHOLIC Physician/Medical LIVER DISCARE attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate ha lirector, page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 🗌 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 0059 185 LLWA, HEUSE OFFICER JAN 14 2504 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21061 301 HUSSITAL DRIVE GIEN BURNIE OHMMAR KHIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 05358 Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** ebrunty 2340 PM SMITH 2004 **MYRTLE** MARIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HAGERSTOWN WASHINGTON WASHINGTON COUNTY HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign
Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🛱 F 214-09-4536 Yrs. 4, 89 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No HAGERSTOWN Director WASHINGTON MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after deeth with 1 nent of Heatth and Mental Hygiene. ont: If Item 27 is marked other then "natural", or Items 23a or: 21740 18507 KENT AVENUE U.S.A. Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 ∰Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CLARENCE E. RUDY NAOMI LOUISE REYNOLDS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GILMER SMITH, STEP SON 1142 ROSEMONT DRIVE, KNOXVILLE, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State Department of H Importent: if Ite any injury or of 2002. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BEAVER CREEK CEMETERY FEB. 9, 04 HAGERSTOWN, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Femery Service 22. Name and Address of Facility 7606 OLD NATIONAL PIKE Kelly A. BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 Zimmerman Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician resulting in death) /Medical Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. the attending physicien IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 1 months? Month Day Year 5 ☐ Other (specify) should be detached 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 No 2 No 1 Yes 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 A inpatient Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire To the Hospitel 29a. Certifier ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier SH-10 Bernstono MD 21713 mipleted cause of death (Item 23a) (Type. rans Rel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 0 3

State of Maryland / Department of Health and Mental Hygiene 2004 05359 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Mitchell Franklin Swope Jr. 3:53**P**M tebruary 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. June 18, 1952) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 → M 2 □ F 212-50-9822 51 Pennsylvania Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits \*how ?7 is marked other than "natural", or Items 23s or 28s-f shov traumatic event, the Modical Examinar must be notified at Md. Washington Hagerstown 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 430 Wood St. 21740 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 64-67 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 64-67 3 Widowed 4 Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within hand Mental Hygiene.
7 is marked other than \*\* Elementary/Secondary (0-12) College (1-4or 5+) Consultant Explosives 12 permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mitchell F. Swope Sr. Angeline E. Willard 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald F. Swope (Son) 1017 Pa. Ave. Hagerstown, Md. 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. 1 ☐ Burial 2 ☐ Cremation Removal from State Smithsburg Crematory Smithsburg, Md. Donation 5 ☐ Other (Sp. 2004 city) Signature of Funeral Service 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home enno Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician 42 resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Due to (or as a consequence of). the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy P in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 🔀 No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Sunpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this filled in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No hours after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Ind. Opal 31. Date filed (Month, Day, Year) State FEB 09 2004 Registrar Been

**ORIGINAL** 

	1	State of Maryland / Depart	ficate of Death	nug. Ivo.
		Decedent's Name (First, Middle, Last)		2. Date of Death  Month  Day  Year  1. Time of Death
Physici		Donald Lee SHIVES, Sr.		72 hruggy 8, 2004 6-30
/Medi Examir			b. City, Town, or Location of Death	4c. County of Death
Exami	er	Washington County Hospital	Hagerstown	Washington
<u></u>		Social Security Number 6, Sex 7, Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foi
Funeral		213-24-7756 1X M 2□F 74 Yrs.	Months Days Hours Min.	(Month, Dey, Year)  Dec. 29 1929  Delaware
Director		Usual Residence of Decedent		
and		10a. State 10b. County 10c. City, Town or Loca	tion	10d. Inside City Lie
anyli	5	77		1 □ Yes 2 <b>X</b>
98 - 1	Director	Maryland Washington Hager	10f. Zip Code	10g. Citizen of What Country?
ith th	吉	10e. Street and Number		
th w 23e		10908 Clinton Avenue	21740	U.S.A.
within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Examinat must be motified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 18. Was Decedent Ever in	is Decedent of Hispanic Origin? (Species, specify Cuban, Mexican, Puerto F	lican, etc.)  14. Race - American molan, Black, White, etc.
after or It		1 Never Married 2 Married 1 N Yes 2 No Il Yes, Give 1 □	] Yes 2⊠ No Specify:	Specify:
ed within 72 hours aft giene. er than "natural", or it in Medical Exam.	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: Korean		White
2 ho	ted		nt's Usual Occupation nd of work done during most of workin	16b. Kind of Business/Industry
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with the	E		onductor	Railroad
Hyg Hyg ther int, I	Ö	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maiden Sumame)
d 2 should be file th and Mental Hy 27 is marked oth traumatic svent	00	Class II Chiron	Mattie	Trumpower
ould Me Mark naric	2	Clay U. Shives  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing		Route Number, City or Town, State, Zip Code)
and and ls r		10000		
and salth n 27		itality bill to	ATT ATT ATT ATT ATT ATT ATT ATT ATT ATT	Hagerstown, Md. 21740 ate 20c. Location - City or Town, State
rmit. Pages 1 a partment of Hez portent: If item y injury or others.		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposit cometery, crematery, crematery, crematery, crematery.	itory or other place) 2/11	104
Page ant c nt: If y or		*4 Donation 5 Other (Specify) Hancock Pr	esbyterian Cem.	Hancock, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Unportent: If item 27 is marked other than "natural; or Items 23s or 28e-1 show any injury or other traumatic svent, the Medical Examinar must be notified at any injury or other traumatic svent, the Medical Examinar must be notified at any once.				innich Funeral Home
Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department		24-100		Hagerstown, Md. 21740
1.00		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dving such as cardiac o	respiratory arrest Approximate
		shock, or heart failure. List only one cause on each line.	, , , , , , , , , , , , , , , , , , , ,	Interval Betwee Onset and Deat
Physician		Immediate Cause (Final disease or condition SEVENE CHARONIC	OBSTANCTIVE PU	LMONARY DISEASE 745
/Medical		resulting in death)  Due to (or as a consequence of):		,
Examiner		h		
	e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		
nsit	Examiner	Cause (Disease or injury		
xecu and	xa	that initiated events c		
cate be executed physician and the burial-transit	a E			
sate shys	dicai	d		
eath certific attending p	0	IF FEMALE:		23d. Date of delivery
The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as	Physician/M		Ectopic pregnancy	Month Day Yea
dea deat	10	1 Yes 2 No gOttoknown	Other (specify)	
trithe de by the tached	Ę,	9 Unknown	17122	
es that igned b	∠ P	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat
uires sign Id be	d b	GASTNOINTESTIAM BLEED		1 12 Yes 2 No 3 Probably 4 Unk
w require been sis	ete	Acute RENA FAILURE		24a, Was an 24b. Were autopsy findings ava
he law requires to has been signed age 2 should be o	ldu			autopsy prior to completion of caus
The are har page	Completed by	VENTRICULAR ECTORY		1 Yes 2 No 1 Yes 2 No
sicien: Th certificate irector, pag	1 0	25. Was case referred to medical	26. Place of Death	(Check only one)
Q0	0	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Ho	me 5 Residence 6 Other (Specify)
Attending Physicien: r death. ector: After this certifies by the funeral director.	H	27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day Year)	28c. Injury at Work?	28d. Describe how injury occurred
ding I	후	1 12 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No	
ttendi death. stor: A	0	3 Suicide 6 Could not be ago Place of Injury - At home farm stre	et, factory, office	28f. Location (Street and Number or Rural Route Number
	Certification;	4 Homicide determined building, etc. (Specify)	,,	City or Town, State)
or All	9		annumed at the time date and alone	and due to the caucale) and manner as stated
ital or Al	- 0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, estigation, in my opinion, death occurr	ed at the time, date and place, and due to the cause(s)
lospital or Al hours after of uneral Directly filled in by	cal	(Check only 2 Medicel Exeminer: On the basis of examination and/or inv		
hs Hospital or Attending Phy in 24 hours after death. The Funeral Director: After this pletely filled in by the funeral d	edical	(Check only 2 Medicel Exeminer: On the basis of examination and/or inv one) and manner stated.	00-11	20d Date signed (Month Day Veer)
i Diffig	Medical (	(Check only one)  2 Medical Examiner: On the basis of examination and/or invariable and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
To the Hospital or Al within 24 hours atter to the Funeral Direc completely filled in by	edical	one) and manner stated.	29c. License number	29d. Date signed (Month, Dey, Year)  02/09/2004
To the Hospital or Al within 24 hours after to the Funeral Direct completely filled in by	edical	29b. Signature and title of certifier  3// Llass 2 Oneth from M.O.	D0051395	29d. Date signed (Month, Dey, Year) 02/09/2004
To the Hospital or Al within 24 hours after a Young To the Funeral Direct completely filled in by	edical	29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, I	D0051395	02/09/2004
To the Hospital or within 24 hours after within 24 hours after To the Funeral Director Completely filled in	edical	29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, I	D0051395	29d. Date signed (Month, Dey, Year)  02/09/2004  1174 107, HACEIS FOLLY MO 3

		1	For State Registrar	State o	of Marylar		artment of H rtificate of I		lental Hyg	iene g. No. 2 (	004	05361
		_	1. Decedent's Name (First, Middle, L.	ast)					2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		Edith Mae Simm	ıs					Jan.		2004	7:45 P M
5	Examin		4a. Facility Name (If not institution, gi	ve street and nu	ımber) ce	enter	4b. City, Town, o	Location of Death		4c. County	y of Death	
			Glade Valley Nu	rsing &			F	alkersvil			deric	
	Funeral		or occurry reality	Sex 1 □ M 2 🖾 F	7. Age (In yrs.		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl Coun	ace (State or Foreign try) 'Land
	Director		215-20-9179			78 Yrs.			May 25,	1925	Mary	land
	pue ≱_	-	Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or L	ocation				10	0d. Inside City Limits
	Aaryli sho	ō	Maryland Carr	·o11		Mt. A	irv					1 ☐ Yes 2 ☑ No
	28a-	Director	Maryland Carr  10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Coun	try?
	with with the sa or		6920 Runkles Ro	ad			2177	1		United	l St	ates
	death with the Maryland ms 23a or 28a-f show	Funerai	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-		ce - Americ	
	r Iter	듄	1 ☐ Never Married 2 ☒ Married		2 🔀 No		If Yes, specify Cubi		Hican, etc.)		ick, White,	
15-003b	within 72 hours after ene. then "naturel", or Ite re Medical Ext. In E	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specit	у: B1	ack
Ş	2 ho	Completed	15. Decedent's (Specify only highest g	Education	3	(Giv	edent's Usual Occup e kind of work done	durina most of work	ina	16b. Kind of B	Business/Inc	dustry
7	P. ". Bu "n Med	pie	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired	d)				
7	od with	no.	6th				Housewife			own ho		
2	be filed within 72 hours after death with the Marylan Hygiene. Id other then "naturel" or flems 23a or 28a-f show the tree made at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination at the Madical Examination a	Be	17. Father's Name (First, Middle, Las	st)				18. Mother's Nam				
<u>a</u>	Ment arkec	2	Mervin Tho	mas		_			Zeigler			
Maryland	permit. Pages 1 and 2 should be filed within 75 Department of Health and Mental Hygiens. Important: If Item 27 is marked other then "na any injury or other treumatic event, Ite Mealt once."		19a. Informant's Name/Relationship	(Type, Print)			ling Address (Street					Code)
Σ	and salth n 27		James A. Simms	Husb			Runkles		t. Airy,			um Ctata
Baltimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from		cemetery, cri	osition (Name of ematory or other pla		Date	20c. Location	- City or 10	wn, State
Ĕ	Pag ment: I ant: I		*4 □Donation 5 □Other (Spec		I	lake Vi	ew Mem. H	ark Feb.	3, 2004	Sykes	ville	, Maryland
ā	portinit.		21. Signature of Funeral Service Lic	0		B	22. Name and Addre	ess of Facility 12	12 W. 01	d Libe	rty R	oad 21784 nfield, MD
m —	80 5 8 9		1 Here &	s (a	ung						FA Wi	
П			23a. art Enter the disease, or co shock, or heart failure. List on	mplications that ly one cause on	caused the dea each line.	ath. Do not e	nter the mode of dyin	ng, such as cardiac	or respiratory arm	est,		Approximate Interval Between Onset and Death
,	Pnysician	8 9	Im solate Cause (Final disase or condition	a	AL	2HEIM	ERS DE	MENTIA				1Eans
	/Medical		resulting in death)	Due to	o (or as a conse	_					-	
и	Examiner		Sequentially list conditions.	b								
	בּי ע	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a conse	equence of):						
	sate be executed ohysician and the burial-transit	Examiner	cause (Disease or injury that initiated events resulting in death) Last	c.	o (or as a conse	aguanca of):					-	
Ö,	oe exectan sourial		Joseph Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Market Ma	Due (c	J (01 as a conse	squerice or).						
8760,	ate b	dical		d								
×	ertific ding p	Me.	IF FEMALE:	23c If yes o	utcome of preg	nancv				23d D	ate of delive	arv.
.O. Box	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 🗀 Live	birth 2 ☐ Fe gnant at time of	ital death 3	☐Ectopic pregnanc	у				Day Year
_ _	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk		dealii 3	Other (specify) _					
Δ.	hat It od by detac	P	Part II. Other significant conditions	s contributing to	death but not re	esulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use cor	ntribute to th	ne cause of death?
Š,	ires t signe	þ	_	ETES					1 □ Y	es 2 🗆 No	3 ☐ Prob	ably 4 Unknown
5	requ	Completed			222011		D15645	6	24a. Was a	24h	Were auto	nev findings available
ec	a law has b e 2 s	jdu	1151	erinc_	OLCLA	3100	1)150431		autops	med2	death?	psy findings available mpletion of cause of
Division of Vital Records, I	: The cate								1 Yes	2 No	1 🗌 Yes	2 No
ij	ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:			Ot	nor .	th (Check only or			
<del>_</del>	Physical this all dir	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1	☐Inpatient 2	☐ ER/Outpati 28b. Time	BUT 2 DOV	4 E Nursing II	ome 5 Reside			y)
Ę.	ling I I. After funer	lo	1 ☑Natural 5 ☐ Pending	(Mc	onth, Day Year)	Injury	Wo	rk? ]Yes 2 □ No		. ,		
Sic	tend death tor: the t	icat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	t be 290 Plan	ce of Injury - At	home farm	street, factory, office		28f. Location (S	treet and Num	ber or Rura	I Route Number,
$\leq$	or A after Direction by	Certification:	4 Homicide determin		lding, etc. (Spec		,		City or Town	n, State)		
_	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a, Certifier 1 Certifying	Physician: To the	he best of mv k	nowledge, de	ath occurred at the t	me, date and place	, and due to the c	ause(s) and m	nanner as s	tated.
	Hos 24 h Fun	Medicai	(Check only 2 Medical Ex	caminer: On the	basis of exami	nation and/or	investigation, in my	opinion, death occu	rred at the time, d	late and place	, and due to	the cause(s)
	o the o the omple	Me	29b. Signature and title of certifiers				29c. Licen	se number		29d. Date sign		
	1	1	1/1/1/	Me		_ Us.	D. D2	6499		1-3	0-6	04
•	WJL		30. Name and address of person w	ho completed ca	use of death (It	tem 23a) (Tvo				_	1	1
	lp		DR. Ronald M	1100	4 (	Culwe	Il Drive	MIX	in with	D 2	117	1
	St	ate	31. Date filed (Month, Day, Year)		. Registrar's Sig	ınature						
	Regist		JAN 3	0 2004	Blosses.	. KK	Boulle ,					
				-	7		175	<del> </del>				

State of Maryland / Department of Health and Mental Hygiene 2 05362 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Day Margaret J. Slick Feb 2004 9:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College View Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F **Director** 217-44-5789 64 June 1, 1939 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exempter roust be notified at 1 ☐ Yes 2√2 No Maryland Frederick Monrovia Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 3908 Rosewood Rd. 21770 United States

14. Race - American Indian,
Black, White, etc. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: φ White 3 

Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Homemaker 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event ang. injury or other traumatic event ang. 18. Mother's Name (First, Middle, Maiden Sumame) Robert P. Bailey Mary Blankenship 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Robert Slick (Son) 3908 Rosewood Rd. Monrovia, MD 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) True Gospel Cem. 2/6/2004 Lisbon, MD 22. Name and Address of Facility
Burrier-Queen Funeral Directors, P.A.
1212 West Old Liberty Rd. Winfield, MD 21. Signature of Funeral Service Licensee Kellnon H 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21784 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY INSUFFICIENCES SDAYS /Medical Due to (or as a consequence of): Examiner YEARS UBSTRUCTIVE PULMONARY TISEACE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the a 9 Unknown 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OBESITY 1 Yes 2 No 3 Probably 4 Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has I page 2 s autopsy performed? Yes 2 certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nutrsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this : After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification; 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the f 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral I

completely filled To the Hospitel Descripting Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examine on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL D-31912 KND 12004 XXX 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julio MENUCIA, MN-1564 UPOSTUMZOWN PINE FREDERILY MD 21702 31. Date filed (Month, Day, Year) State FEB 0 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05363 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 27, January 2004 1:15am Tyrone Smallwood Ralph\_ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 15 M 2□ F 22,1940 Director Feb. Washington, D.C 577-54-8051 63 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Exacding count be notified at 1 Yes 2 □ No Washington D.C. Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code ŏ or Items 23a 9918 Eastern Ave. N.E. 20019 United States Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: Black þ 3 Nidowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Private College (1-4or 5+) Elementary/Secondary (0-12) Mail Clerk permit. Peges 1 and 2 should be file Department of Health and Mental Hy, Important: if Itam 27 is marked oths any injury or other traumatic event, once. 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Delores Davidson Ralph E. Smallwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaTonya S. Proctor / Daughter 9929 Goodluck Rd. #T1 Lanham, Md. 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Feb.7,2004 Landover, Md. 21. Signature of Funeral Service Vcensee 22. Name and Address of Sacility Pope Funeral Homes 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike/Forestville, Md. 20747 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Urosepsis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): physicien Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Recent Myocardial Infarction 24a. Was an autopsy page performed? 1 Yes 1 Yes 2 No 2 X No or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 2 Accident the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D52261 January 27, 2004 enu w of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause Alan R. Segal, M.D. 1500 Forest Glen Rd. Silver Spring, Md. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 05364 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** VIRGINIA SERENE S. 29, 2004 JÄNÜARY 7:00 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Bedford Court Healthcare Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Aug. 1, 1915 9. Birthplace (State or Foreign **Funeral** Days 577-20-8795 Hours 1 □ M 2√2 F 88 Virginia Director Usual Residence of Decedent 10b. County 10c. City, Town or Location \* show 10d. Inside City Limits r 28e-f show 1 ☐ Yes 2√ No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be 238 20904 621 Hobbs Drive United States Funerai or Itams 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No þ If Yes, Give Year or Dates: Specify: White Specify: 3X Widowed 4 □ Divorced natural Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) Secretary Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I ant: If item 27 is marked o Robert L. Shumate Virginia Akers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 621 Hobbs Drive Silver Spring, Maryland 20904 Katherine Rodeffer -niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If its
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 2.3.2004 Brentwood, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licer Donald V. Borgwardt Funeral Home, P.A. Denald U, wa 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebrovascular disease disease or condition 3 years resulting in death) /Medical Due to (or as a consequence of) Examiner Chronic Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. ☐Yes 2 🗰 Yo detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by congestive heart failure; hypertension 1 ☐ Yes 2 ◯XNo 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? was a... autopsy performed? Yes 2X No certificate 1 ☐ Yes 2 ☐ No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2 No 2 in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò Hospitel (24 hours at Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 24 within 2 Ë 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 10 D30844 January 30, 2004 30. Name and address of person who completed cause of peach (Item 23a) (Type, Print)

James F. McMurry Jr., M.D. 4701 Randolph Road, #103 Rockville, Maryland 20852 31. Date filed (Month, Day, Year) FEB 0 3 2004 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

			1 = For State 2-3-04 Ragistrar Amend # 26. Per		and / Dep	artme	nt of H	ealth and	Mental H	ygien Reg. N	<sup>e</sup> 200	05365
	Physici		Decedent's Name (First, Middle, La     George Paul Sto	,					2. Date of Month Janua	Da	5, 2004	3. Time of Death
7	/Medi Examir		4a. Facility Name (If not institution, giv			4b. City	, Town, or	Location of Dea			C. County of De	
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	anylan show		10a. State 10b. County		City, Town or L							10d. Inside City Limits
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9	after or Iter	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give					Specify Yes or I nto Rican, etc.)	10-	Black, Wi	nite, etc.
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215-0036	n 72 "na"	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece (Give	dent's Use	ual Occupa	tion uring most of w	orking	16b. K	(ind of Busines	s/Industry
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p	2 should be filed withing and Mental Hygiene. Is marked other than raumatic event, the M	Вес	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First, Midd	le, Maider	Sumame)	Overment
Ya	ould to	10	George Paul						Mae Be			
Maryland	permit. Pages 1 and 2 should lopermit. Pages 1 and Men Depertment of Health and Men Important: If item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship ( Ethel R. Stokes/W						Rural Route Num Hgts., M		or Town, State, 20743	Zip Code)
	s 1 an f Heal ftem 2 other		20a. Method of Disposition		b. Place of Dispo				Date Date		ocation - City o	r Town. State
Baltimore,	Pages hent of int: If i		1X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		t. Linco				/04		ntwood,	
alti	permit. Depertrimports any inju		21. Signature of Funeral Service Licen		2:	2. Name a	nd Address	of Facility	<u> </u>			T.C.
	807 2 2 3		23a. Part1. Enter the disease, or com shock, or heart failure. List only	Jaco	40	н.S. 925 в	Washi urrou	ngton & ghs Ave	Sons C	o. Ir Wash	nc. D.C.	20019
	Physician /Medical Examiner physician and physician and physician and physician site physician are physician and physician are physician and physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are physician are p	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>—</b>	PTE sequence of):  2 +EW	CAT	DIDI					Interval Between Onset and Death
κ 68760,	adificate b ing physic e as the b	Medical	IF FEMALE:	d								
P.O. Box	law requires that the death certifica as been signed by the attending ph. 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preduction 1 ☐ Live birth 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐ Figure 2 ☐	etal death 3	Ectopic p Other (s)					23d. Date of de Month	blivery Day Year
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ဝွ	aw requir is been si 2 should I	Completed							24a. Wa	s an	24b. Were a	utopsy findings available completion of cause of
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of	Phys. this cral dir	2	1 ☐ Yes 2 € No  27. Manner of Death	Hospital: 1 ☐ Inpatient 2  28a. Date of Injury	☐ ER/Outpatien			4 Maryursing F	forme 5 □ Res			ecity)Hospice
Ö	Attending For death.  Sector: After by the funer.	tion	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	) Injury	M	28c. Injury : Work?	at es 2 ⊡No	28d. Describe	how infur	y occurred	
Division	l or Attend after death Director: /	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - Af	t home, farm, str	eet, factor			28f. Location	(Street an	d Number or F	ural Route Number,
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	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1  Certifying Phone 2  Medical Exem	/sician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, death ination and/or inv	occurred vestigation	at the time	, date and place nion, death occu	e, and due to the urred at the time	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	withi To t	Σ	29b. Signature and title of certifier			1	c. License	_			e signed (Mon	
	0	-	> Steen Tu				046	998		Janu	ary 29	,2004
	(3)		30. Name and address of person who o				. Д 1	Thechi				
	Sta	te	Steven Tee, M.D. 31. Date filed (Month, Day, Year)	Registrar's Sig	nature	oulte e	#   ,	нуаtts	VIIIe,M	1. 20	782	
	Registr	_	FEB 0 3 2002	7. Registrar's Sig	K Apo	W						

State of Maryland / Department of Health and Mental Hygiene 2004 05366 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month Day Year **Physician** Milton Smith 21 January 2004 5:00AM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Crescent Cities Genesis Elder Care Riverdale Prince George's If Under 24 Hrs. Hours | Min. If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Months 1 NM 2 F Days Director 260-30-5808 76 Feb. Georgia Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 11 Yes 2 □ No Director District of Columbia Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? thems 23s or 401 K St., N.W. #231 Funeral 20001 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White etcan 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: δ Specify: American 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 3rd Cement Finisher Private ulth and Mental Hygie 27 is marked other if r traumatic event, 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ovie Smith Lemma L. Ford 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Paulette D. Edge - Daughter 11401 Clover Dr., Seaford, DE 19973 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6 1 DrBurial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Ft. Lincoln Cemetery 1/31/04 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Qa. **Examiner** Due to (or as a consequence of): Examiner burial-trensit Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the t Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown δ certificate has been signe irector, page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 0 No 1 ☐ Yes 2 ☐ No After this certification funeral director, 25. Was case referred to medical e 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 SNatural 5 Pending 1 Tes 2 No s efter deeth.

I Director: A

d in by the fu deeth. investigation 2 Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours or To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of death (ttem 23e) (Type, Print) DEPORTUD 4203 QUEENSAUNG LA HYETTSVIKE MA 20181 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 3 2004 Registrar

			1 - For State Registrar	State of	Marylan	d / Depa <i>Cei</i>	artment <i>tificate</i>	of H	ealth a Death	and Mei	ntal Hygi	ene 2 0	04	05367
	Physici	an	Decedent's Name (First, Middle, L.	ast)						2.	Date of Death Month	Day	Year	3. Time of Death
	/Medic			AUGHTER							nuary		04	4:45 A <sup>M</sup>
	Examin	ier	4a. Facility Name (If not institution, g		oer)				Location o	of Death		4c. County		
			MARINER HEALTH  5. Social Security Number 6.		Age (In yrs. I	last birthday)	BETH If Under 1		If Under 2	24 Hrs. 8	Date of Birth	MONTG		Nace (State or Foreign
	Funeral Director		252-42-4999	1 <b>∏</b> M 2□ F	76	Yrs.	Months	Days	Hours		Date of Birth (Month, Day, pt.11.		Cour	icello,GA
			Usual Residence of Decedent						-		prom			
	ehow	_	10a. State 10b. County			y, Town or Lo							1	0d. Inside City Limits 1  Yes 2  No
	88 -1 M	Director	Maryland Montgom	ery		Bethes	1	N. d.			140	g. Citizen of	14/1 0	
	with	ᡖ	10e. Street and Number				10f. Zip (				10	•		itiy?
	ne 23	Funeral	5721 Grosvenor L  11. Marital Status	12. Was Deced	ent Ever in U.	S. 13. V		0814 nt of His		gin? (Specify	Yes or No-		SA ce - Americ	ean Indian,
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8	ral', o	호	3 Widowed 4 Divorced	If Yes, Give Year or Date	es:		I□Yes 2	No.	Specity:			Specif	y: Bla	ack
21215-0036	within 72 hours effer deeth with the Maryland ene. than "netural", or Iteme 23a or 28a-f ehow than "medical Examinar must be notified at	Completed by	15. Decedent's (Specify only highest of			16a. Deced (Give	lent's Usual kind of work DO NOT use	Occupa done di	tion uring most	of working	1	6b. Kind of B	usinøss/In	dustry
121	within ne. than	ם	Elementary/Secondary (0-12)	College (1-4	or 5+)		iter	retired)			D	rivate	Indu	strv
42	Hygie ther int,		12th 17. Father's Name (First, Middle, Lat	st)					18. Mother	r's Nam <i>e (F</i>	irst, Middle, M			
Maryland	id be ked c	To Be	John Bell						Ca	rrie (	lemons	-Be11		
ary	e mar		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (	Street a	nd Numbe	r or Rural R	oute Number,	City or Town,	, State, Zip	Code)
	and 2 salth on 27 i		Vannetti Carter/	niece					Sout	h St.E	etersb	urg,FL	337	712
altimore,	of He refre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□Removal from St.	1 6	lace of Dispo emetery, cren	sition (Name natory or oth	of er place	) 1	/30/02	2	0c. Location	- City or To	own, State
Ë	Peg ment tant:		* 4 □ Donation → 5 □ Other (Spec	city)	Rive	erdale				-		verdal	le, Mo	d
Ball	permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryle Depertment of Health end Mental Hygiene. Important: If item 27 ie marked other than "netural", or Iteme 23a or 28a-1 ehow eny injury or other traumatic event, the Madical Examinat must be notified at once.	l h	21. Signature of Fuperal Service Lic	les		- 1					e, Inc Wash.		001	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau ly one cause on eac	sed the death h line.	. Do not ente	er the mode	of dying	, such as o	cardiac or re	spiratory arres	st,	001	Approximate Interval Between
8	Physician		Immediate Cause (Fine)		even	Far	lun							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):	1/ 1							12.
	_xammor	<u>.</u>	Sequentially list conditions,	b. Dwats for	as a consequ	of 1	100	neg	1				/	righten
	nsit	듣	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	223 10 (0.	20 20 00 110 040	3,40 0.7.								
ć	be executed siclen end buriel-trensit	Examiner	that initiated events resulting in death) Last	C. Due to (or	as a consequ	ience of):								
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89	ng ph	Med	IF FEMALE:											
Box	death certifice attending ph d for use es t	an/	23b. Was decedent pregnant in the past 12 months?		n 2 ∐Fetal	death 3	Ectopic pre						te of delive	ry Day Year
-	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnan 9☐ Unknow	at tim <i>e o</i> f de n	eath 5□	Other (spec	cify)				1810		<b>54</b> , 154.
P.0	thet the d ed by the deteched		Part II. Other significant conditions	contributing to deal	h but not resu	ılting in the ur	derlying cau	ise giver	n in Part I.		23e. Did toba	icco use cont	tribute to th	ie cause of death?
ds,	uires the signed Id be de	d b	Middle or	belt							1 🗌 Yes	2 No	3 🗌 Prob	ably 4 Unknown
Ö	w require been si should b	ete	COID	•							24a. Was an	24b.	Were autor	osv findings available
of Vital Records,	The lav	Completed by	Po od to	1.00.1							autopsy performe		prior to cor death? 1 □ Yes	psy findings available inpletion of cause of 2 No
ital		0	25. Was case referred to medical	ani					26. Place	of Death (C	1□ Yes 💥 heck only one,	<b>XX</b>		20140
<b>&gt;</b>	2 5 5	ToB	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inp		ER/Outpatien	3 □ DOA	Other	r: 4 Nur	rsing Home	5 🗌 Residen	ce 6 □Oth	er (Specify	')
	5 e e		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of (Month,	njury Day Year)	28b. Time of Injury	- 3	. Injury Work	?		Describe how	injury occur	red	
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Division	s after all Direction by	Certification;	4 Homicide determine	d 286. Place of building	Injury - At ho , etc. (Specify	')	et, ractory,	omice		201.	City or Town,		er or nura	noute Number,
	To the Hospitel or Attendit within 24 hours after deeth. To the Funeral Director: A completely filled in by the funeral or the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the funeral by the	Medical	29a. Certifier 1 Certifying F   Medical Exponent	Physician: To the beaminer: On the basi and manner	s of examinati	wledge, death ion and/or inv	occurred at estigation, in	the time	e, date and nion, death	d place, and h occurred a	due to the cau t the time, dat	se(s) and ma e and place,	anner as stand due to	ated. the cause(s)
	To th Withir To th comp	ž	29b. Signature and title of certifier	1/2 17	10		29c.	License	number 5	-	290	d. Date signed	d (Month, L	Day, Year)
	(2)		30. Name and address of person wh	o completed cause	of death (Item	23a) (Type !	Print)	,	110	2	12	ving	, 20	
/	d)		+1/1 / i )	nan 141		10 E7	Per. T	111	31	~ 1	Roch	ille 1	140	70827
	Sta Registr		FEB 0 5 2004		, J.	food								

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State of Maryland / Department of Health and	Mental Hygiene 2004	536

78	35		1 - For State Registrar	State of Marylan	d / Depa	artment of He rtificate of D	ealth and Death		jiene <b>2 ()</b> leg. No.	04	05368
			Decedent's Name (First, Middle, Little)	ast)		timodio oi E	, , , , , , , , , , , , , , , , , , ,	2. Date of Dea	th	Jan 1	3. Time of Death
	Physici /Medic		NATASHA MAR	IE STRINGFELLO	OWWC			Januar	Day 28, 2	Year 2004	2:15 PM
	Examin		4a. Facility Name (If not institution, gir			4b. City, Town, or		th	4c. County		
			4092 Warner Aven 5. Social Security Number 6.	iue C4 Sex 7. Age (In yrs.	last hirthday	Landover	Hills If Under 24 Hrs	S. B. Date of Birth	Princ	ce Geo	
	Funeral Director			1□M 2X F 24	Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day May 13,	Year) 1979	Wash	nce (State or Foreign y) .,D.C.
	pu 🟃		Usual Residence of Decedent  10a, State 10b, County	10c Cit	y, Town or Lo	reation					d. Inside City Limits
	Aaryla f sho	ō		100. 51						100	1 X Yes 2 No
	728e-	Director	D.C. 10e. Street and Number		Washi	10f. Zip Code			10g. Citizen of	What Countr	y?
	th with		2210 21st Stree	t. N.E. #145			20019		U	<b>ISA</b>	
	be filed within 72 hours after death with the Maryland stal Hyglene. id other than "naturel", or Items 23a or 28e-f show event. I've Medical Examination into the conflict at	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of His If Yes, specify Cubar	spanic Origin? (	Specify Yes or No- rto Rican, etc.)		ce - America ck, White, et	
50	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		1⊡Yes 2√2 No	Specify:		Specif	y: <b>B1</b> a	ck
215-0036	'2 hou nature		15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	tion	adein a	16b. Kind of B		
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2	filed within 72 Hygiene. other than "nai		12th 17. Father's Name (First, Middle, Las	*)	1	Custodia		me (First, Middle,			Terminal
auc	d be f	To Be	Unkne								
Maryland	should be and Mental amarked umatic ev	۲	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street a		Doreen St Jural Route Number			Code)
Ξ,	and 2 eaith a n 27 is		Joseph Stringfel				Temple		20748	3	
Baltimore,	ges 1 it of Hi if iter or oth		20a. Method of Disposition 1   Tagranial 2 ☐ Cremation 3 (	☐Removal from State	emetery, cre	osition (Name of matory or other place		Date	20c. Location -	City or Tow	m, State
	it. Pe irtmen rtant: njury		* 4 ☐Donation 5 ☐ Other (Special Signature of Funeral Service Lice			et Cemeter  2. Name and Address		/04	Wash.,D	C	
E E	permit. Peges 1 and 2 should be Department of Health and Menta importent: If Item 27 is marked eny injury or other traumatic e <u>once</u> .			1	E~	aziorio P	unovol 1	Home, Inc			
	*		23a. Part1. Entertitle disease, or spr shock, or healt failure. List only	polications that caused the deat	h. Do not en	9 R.I. Av	e N.W. , such as cardia	c or respiratory an	DC 200	001	Approximate nterval Between
2	Physician		disease or condition	Gunsho	t wo	und of	bond				Onset and Death
æ	/Medical Examiner		resulting in death)	Due to (or as a conseq		,	7 7 1000				
Ŗ.		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):						
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Ď,	icate be executed physicien and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):						
8760,		dlcal		d							
ROX	es that the death certifi igned by the attending be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Da	te of deliver	/
	death	sicia	in the past 12 months? 1 X Yes 2 ☐ No	1 Live birth 2 Feta 4 XPregnant at time of d 9 Unknown		JEctopic pregnancy Other (specify)			Mo	onth D	Day Year
J.	at the	Phys	9 Unknown			-10-10 C S V		00. 0:11			
ds,	law requires that the as been signed by th 2 should be detache	by	Part II. Dther significant conditions	contributing to death but not res	uiting in the u	nderlying cause give	nın Parti.	230. Did to	_		cause of death?
000	w require been signature	ompleted						24a. Was a			sy findings available
Ř	0 - 0	dmo						autops	med?	prior to comp death?	pletion of cause of
Vital Records,	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only or		Xies 2	□ No
	Physician: this certific ral director,	2	Yes 2□No	1.		nt 3□ DOA Othe	4   Nulsing I				At scene
u C	ding h. After funer	tlon:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury Work	?	28d. Describe h	ow injury occur two	/	
Division of	al or Attendi after death. I Director: A d in by the fu	flca	3 ☐ Suicide 6 ☐ Could not	28e. Place of Injury - At he	2,00 ome, farm, st			28f. Location (S	reet and Numb		Route Number,
	tel or	Certification:	4 Homicide determined	building, etc. (Specif	y) navtme	H		HUG2	n, State)	en Ave	MO
	Hospitel or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	edical	Check only 21 X Medical Exa	hysician: To the best of my knominer: On the basis of examina	wledge, deat	h occurred at the time	e, date and plac inion, death occ	e, and due to the c	ause(s) and ma	anner as stat	led. he cause(s)
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License	number	2	9d. Date signe	d (Month, Di	ay, Year)
			Jasha A &	Jeerbey M	n	O.C.M	.E.	т.	anuary	29 21	004
)	[2]		30. Name and address of person who	completed cause of death (Iten	n 23a) (Type,	Print)		U	шлину	27, 4	
	()		31. Date filed (Month, Day, Year)	enberg M.D.	turo	111 Pen	n Stree	t, Baltim	ore, Ma	arylan	d 21201
	Sta Registi		FEB 0 5 200	enberg M.D.  Registrar's Signa  4	Spe	le					

State of Maryland / Department of Health and Mental Hygiene 2004 05369 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4:38 P. M **Physician** Sumlin 30, 2004 January Pernel1 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince Georges Fort Washington Fort Washington Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 1933 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Months **Funeral** Days Hours 1 XM 2 ☐ F 70 Yrs. November 22, Washington, D.C Director 225-38-8433 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State r than "natural", or itams 23a or 28a-f ahow the Medical Examinat must be cottilled at 1 Yes 2 □ No Fort Washington Director Maryland Prince GEorges 10g. Citizen of Whal Country? 10f. Zip Code 10e. Street and Number United States 20744 2813 Rose Valley Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Ammed Forces? Dec 1 Xyes 2 □ No 1951 Il Yes, Give Year or Dates: Sept.1957 Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify. Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Limousine Driver Limousine Services years is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be f Mental I Sumlin Inez Virginia Berry .John ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748 19a. Informant's Name/Relationship (Type, Print) and (Wife) permil, Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trac 2813 Rose Valley Drive; Fort Washington, Maryland Christine Bussey Morris-Sumlin Feb. 5, 2004 Cheltenham, Maryland 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1★ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Cheltenham Veterans Cemetery 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. 21. Signature of Funeral Service Licensee anemi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Anset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Poura or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a conse Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 12 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes 27 No 26. Place of Death (Check only one Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Appatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27 Manner of Death After Netural 5 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - Al home, larm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D46046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amir Mirza-Alikhani, M.D.; 11711 Livingston Road; Fort Washington, Maryland 20744 31. Date filed (Month, Day, Year) State FEB 0 5 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H	eaith and N Death	fental Hygie	ne 2004	05370
			Decedent's Name (First, Middle, Last	st)				2. Date of Death		3. Time of Death
	Physicia		KEBBA	C. SALI	_AH			Feb.5,20	Day Yeer	10:30p M
	/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Deat	
		Ç.	SHADY GROVE H	OSPITAL		ROCKV	/ILLE		MONTGON	1FRY
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs.	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Sept. 28	ar) 9. Birt	hplace (State or Foreign untry)
	Director		Unavailable 1	ØM 2□F 74	Yrs.	Wichians Days	110010	Sept.28	,1929 (	Gambia
	2 -	-	Usual Residence of Decedent  10a, State 10b, County	10c Cib	y, Town or Lo	ncation				10d. Inside City Limits
	arylar shov	_				Potomac				1X□Yes 2□No
	8. 9. M	Sct		gomery in	) I C ! !			100	Citizen of What Co	
	vith th	E C	10e. Street and Number			10f. Zip Code 20878			Gambia	ond y r
	s 23	Funeral Director	6 Driscoll Ct.	12. Was Decedent Ever in U.	C 12	Was Decedent of Hi	ienanic Origin? (Sr		14. Race - Ame	rican Indian
	er de	nu	11. Marital Status  1 □ Never Married 2 X Married	Armed Forces?	3. 13.	If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Whit	
36	rs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: B	lack
몽	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23s or 28s-f show ent, the Medical Examb at marker notified at	ed	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occupa	ation	16b	. Kind of Business/	Industry
5	n n	plet	(Specify only highest gra	Callege (1 40: 5:)	life.	kind of work done of DO NOT use retired	()	ung (		Ministry
212	y with	Completed	Elementary/Secondary (0-12)	4 Conege (1-401 5+)	Civi	1 Servar	nt .		of Finaı	nce
2	be filed within 72 hours after death with the Marylan Hygiene.  do other than "natural", or flems 23a or 28a-f show avent, the Medical Examt at mall be notified at	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, Maid	den Sumame)	
<u>a</u>	should be tod Mental marked o umatic ave	To B	Cherno Salla	h			Yasig	i Sallah		
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other than aumatic avent, tha M		19a. Informant's Name/Relationship (					ral Route Number, Ci		
Σ.	and 2 ealth n 27 I		Babou Sallah-S		_		St, Nort	n Potoma		
ore	of He		20a. Method of Disposition  1 XBurial 2 Cremation 3	On an annual from Chata	emetery, crei	sition (Name of matory or other place		Date 200 1 / 0 4 B	Location - City or	
Ĕ	Pag ment ant: I ury o		'4 □Donation 5 □Other (Specifi		•	Cemetery		3		
Baltimore,	permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 Is marker any injury or other traumatic once.		21. Signifue of Funeral Service Licer	n Mala	22	2. Name and Addres	ss of Facility Un	iversal	II Mort	uary Inc.
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8			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
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16 C	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					
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	and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):					
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387	phys the	dicai		_ d						
9 X	death certifica attending ph I for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	ancy				23d. Date of del	ivery
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ص	res that igned b be deta		Part II. Other significant conditions of	contributing to death but not res	ulting in the u	inderlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
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Be	he lav e has age 2	Completed						autopsy performed 1 ☐ Yes 2 🔀	<pre>1? death?</pre>	completion of cause of 2 ☐ No
Vital	ician: Th certificate rector, pag		25. Was case referred to medical				26. Place of Dea	th (Check only one)	140	2010
>	ysician: The is certificate hadirector, page	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Oth		ome 5 Residence	e 6 □Other (Spe	city)
0	g Phys er this eral di	n; T	27. Menner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of	of 28c. Injury World	y at	28d. Describe how i	njury occurred	
<u>0</u>	ath. r: After e funer	atio	1 Natural 5 Pending 2 Accident investigation		пусту		Yes 2 □No			
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	the H hin 24 the F nplete	ledical	one)	and manner stated.	tion and or i					
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens	e number		Date signed (Mont	•
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)	(2)		30. Name and address of person who			Print)			7.5	
	()		Leo Shue,M.			al Cent	er Dr,R	ockville	,Maryla	nd 20850
	Sta Regist		31. Date filed (Month, Day, Year) FFR 0 6 2004	32. Registrar's Signa		2.				

harles qual CTB

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 05371 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** CHARLES OLIVER SIMMS JANUARY 27 2004 9:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner WICOMICO NURSING HOME **SALISBURY** WICOMICO II Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 04-12-1912 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F Yrs 91 SUMMERFIELD, MD. Director 217-12-4989 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov itam 27 is marked other than "natural", or items 23a or 28a-f abor other traumatic avant, the Medical Examples must be notified at 1 Tyres 2 □ No MD WICOMICO PARSONSBURG Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32110 OLD OCEAN CITY ROAD 21849 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2☐No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced Year or Dates WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filad w Depertment of Health and Mantal Hygien Important: If item 27 is marked other th. any injury or other traumatic avent, <u>Ites</u> 2006. CARPENTER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN E. SIMMS GERTRUDE BAYNES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY LEWIS - DAUGHTER 32110 OLD OCEAN CITY RD. PARSONSBURG MARYLAND 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) LEWIS CEMETERY 01-30-2004 WILLARDS, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN SIREET, SALISBURY, MARYLAND 21804 art1. Enter the dise, of shock, or hear failure. ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, my one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CORONARY Physician AFTER /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events by Physician/Medical Examiner Due to (or as a consequence of): The law raquires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): physicien IF FEMALE: use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detachad 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 1□ Yes 2□No director, 25. Was case relerred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 1 Yes 2 100 /4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 4-☐Natural 5 Pending investigation death. 1 Yes 2 Accident within 24 hours after deal To the Funeral Director 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Cedifier completely 29c. License number 29d. Date signed (Month, Day, Year) 4114 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAN BHAT M.D. 614 FASTERNSHORE DRIVE SALISBURY NO 21804 32. Registrar's Signature 2 9 2004 State Registrar

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п	Funeral		5. Social Security Number 10 6. Sex	7. Age (In yrs. la		If Under Months	1 Year Days	If Under 24 Hours	Min. (Mo	of Birth	'ear)	9. Birthp Coun	lace (State or Foreign
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	land		10a. State 10b. County	10c. City,	Town or Lo	cation						10	0d. Inside City Limits
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	be filed within 72 hours after death with the Maryland nal Hygiene. Independent than "natural", or items 23e or 28e-1 show event, the Medical Exeminer must be notified at	Funeral	11. Marital Status 12. Was Dece Armed Fo	dent Ever in U.S	. 13. \	Vas Deced	ent of Hisc	anic Origin	n? (Specify Ye	or No-	14. Rac	e - America	
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Maryland	ould be Mental I	o Be	Harry Walter Burgner					Eva			erlin	<b>u</b> /	
<u></u>	should be and Menta a marked umatic ev	2	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	a Address	(Street and		or Rural Route			State Zin	Code)
	and 2 Balth a n 27 is		Geoffrey B. Smoot/son						e Dr.,				
ē,	_ =		20a. Method of Disposition	000	ce of Disponentery, cren	sition (Nam	e of		Date	20	c. Location -	City or Tox	wn, State
E	Page nent c		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from :  4 ☐ Donation 5 ☐ Other (Specify)	State	sbury			y   1.	/30/04	S	alisbu	ırv, l	MD
Baltimore,	permit. Pages 1 Department of H Important: If its anylinjury or ot once.		21 Signature of Funeral Service Licensee		22	Name and	Address						sociation
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н			23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. ach line.	Do not ente	er the mode	of dying,	such as ca	rdiac or respira	tory arrest			Approximate Interval Between
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0			30. Name and address of person who completed cause	of death (Item 2)	3a) (Type, F	rint)	11	10		-		0 (	
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			State of Mary	land / De	partmer e <i>rtifica</i> i	t of He	ealth a	and Me	ental Hygi	ene 2 (	004	05373
Physic /Med Exam	ical	1. Decedent's Name (First, Middle, Last)  EDWIN R. TUBE  4agFacility Name (If not institution, give st	reet and number)	Center	4b. City	Town, or	Location o		2. Date of Death Month Februari	4c. Count	Year 2004 by of Death	3. Time of Death 1243 M
Funera Director		5. Social Security Number <i>J</i> 6. Sex 213–24–1881 1 ☑		n yrs. last birthda Yrs.	Months	Days	If Under : Hours	24 Hrs. 8 Min.	3. Date of Birth (Month, Day, 1-29-19.	(ear) 30	9. Birthpl Coun WILL	ace (State or Foreign try) ARDS, MD
death with the Maryland ms 23a or 28a-f show	Director	Usual Residence of Decedent  10a. State  10b. County  DELAWARE  SUSSEX  10e. Street and Number	10	c. City, Town or	L	o Code			10	g. Citizen of		0d. Inside City Limits 1 ☐ Yes 2 ☐ No
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C, MG 1 and 2 s Health ar am 27 is ther trau		19a. Informant's Name/Relationship (Type MARJORIE D. TUBBS/20a. Method of Disposition	WIFE	285 20b. Place of Dis	27 LAS	TON I	RD, L		DE 1			
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Physician /Medica Examine		23a. Part1. Enter the disease, or complic shock, or heart failure. List of your limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as a c	APNEIC prisequence of):		PIRAT	ORY	F	PILURE		JP.	Approximate Interval Between Onset and Death
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that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of p 1 Live birth 2 [ 4 Pregnant at tim 9 Unknown	Fetal death	3 □Ectopic p 5 □ Other (s						ate of deliver	ry Day Year
8 8 8 N	þ	Part II. Other significant conditions cont	ributing to death but n	ot resulting in the	underlying	cause give	n in Part I.					e cause of death2
The law ate has b page 2 st	Completed	PULMONARY FI ATRIAL FI	BRILLATI	510N			<del></del>		24a. Was an autopsy perform		prior to con death?	sy findings available apletion of cause of
Of Vital I Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 (Unpatient	2 ER/Outpat	ient 3 D	Othe	-		Check only one e 5 ☐ Residen		her (Specify	1
After fune	cation; T	27. Manual of Death  1 Vivatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yo	28b. Time	of	28c. Injury Work	at	28	3d. Describe how			
= = = = = =	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	Specify)					If. Location (Stre City or Town,	State)		
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To the within 2. To the I complet	Σ	29b. Signature and title of certifier	11 1	M	29	c. License	number	SIZ	290	Date signe	ed (Month, L	Day, Year)
43		30. Name and address of person who cor	npleted cause of deat	n (Item 23a) (Typ	-					1-1	7	4 - 3 -
S Regis	tate	31. Date filed (Month, Day, Year) FEB 1 1 200	32. Registrar's	Signature	hard.	456	ASTE	RNS	HOREDA	JAU.	SB UKY	MO21804

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10.25 AM 31d 2004 OROTH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Western Maryland Hospital Center Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F 23 1929 Maryland Director 218-24-9540 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturel", or Items 23a or 28e-f show ury or other treumatic event, the Madical Exams are marked to nothined at 10a. State Y☐Yes 2☐No Directo Hagerstown Maryland Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21742 817 View Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 0 Owner/Operator Diner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frances Rhoades Wesley Resh ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 179 E. Walter Dr. Greencastle, Pa. 17225 Frances M. Clingan - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 2/7/04 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury of Hagerstown, Maryland Broadfording Mem. Gardens \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service License Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 100 2 WEEK /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: W Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 2 this After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 Tes 2 No I Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Ho*m*icide 24 hours a Funerel ( 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and tatle of certifier 29c. License number 034165 ind. February 3rd, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue 10 HAMMED ALI Hagerstown, MD 21742 32. Registrar's Signature 31. Date filed (Month, State Registrar

			For State Registrar		State of	Marylan	d / Depa		Health and	Mental H	ygiene 2	04	05375
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*	Physici /Medic		David	R. Tigno	r, Sr.					Januar	u 31 2	004	0247
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Pt. Known as Tignor, Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heatilh and Mental Hygiene. Importent: if Item 27 le marked other then "naturel", or Iteme 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	1 Never Man	ried 2⊠ Married 4 □ Divorced	1 Tes 2 If Yes, Give Year or Dat	2 XNo		1 ☐ Yes 2 ☑ No		orto ritoari, etc.,	Specify	k, White, e	
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	10		30. Na and ddi	ress of person who	completed cause	of death (Item	23а) (Туре, І	Print)	m 10	R.11	mA	21	15
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State of Maryland / Department of Health and Mental Hygien 2004 05376 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WOODROW WILSON TURNER JANUARY 25, 2004 4:10 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SARAH MARGARET AND MOLLIES PLACE SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
August 27,1929 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 3 M 2 ☐ F 213-24-2525 74 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🖾 No Director Maryland Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or itams 23e or 9288 Hickory Mill Rd. 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1 X Yes 2 □ No Army 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No ģ If Yes, Give Year or Dates: Specify: white 3 ☐ Widowed 4 ☑ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) 5 College (1-4or 5+) carpenter construction other ( 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if itam 27 is markad oth any liury or other traumatic evant 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Be Turner Jay Susan Bramble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria J. Kelly/daughter 35019 Mt. Hermon RD, Pittsville, MD 21850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Memory Gardens ' 4 ☐ Donation 5 ☐ Other (Specify) 1/29/04 Hebron, MD 21. Signature of Funeral Service License <sup>22, Name and Address of Facility</sup>
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 Cutt 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE **Physician** CHRONIC /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, Completed by Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes ₽ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) LIVING Certification: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury s after dea. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Hernicide within 24 hours a

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completely fitted Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29t nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAHON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY EASTERN SHOPE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05377 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 10 2004 0430 A M Drew Hureen Tolliver /Medical 4c. County of Deeth 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Elkton Union Hospital If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 21, 1920 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F West 83 Director 235-26-6470 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or Items 23a or 28a-f show the Medical Examinar must be rigilized at 1 ☑ Yes 2 ☐ No Director Elkton Maryland Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 United States 24 Hollingsworth Manor Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Eyer in U.S. Armed Forces? WOYLO 1 XYes 2 No War 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes XXNo Specify: Specify: If Yes, Give 3 Widowed 4 Divorced II White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Automotive Wheel al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Automotive Wheel Fabricator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and Mental H Item 27 is marked ott Be Roxey Mulliens John Howard Tolliver ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Pauline Tolliver/Wife 24 Hollingsworth Manor, Elkton, Maryland 21921 other 20b. Place of Disposition (Name of cametery, crematory or other place)
Delaware Veterans
Memorial Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot Pages February 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 13, 2004 Bear, Delaware 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee ed 103 W. Stockton Street, Elkton, Maryland 21921 200 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Septicemin Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rd:ac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exan iner law requires that the death certificate be executed Due to (or as a consequence of) attending physicien Physician/Medical as the USB 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ be 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed certificete 2□ No 1 ☐ Yes 2 PINO 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA P 1 Tes this funeral 27. Mann of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the the within To the 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature-and 10059640 30. Name and address of person who completed cause of death (Item 23a) (Type. Print) DG BOWSTAKKT . Registrar's Signature 31. Date filed (Month, Day, Year) State 1 9 2004 Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

P.0.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05378 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Barbara Annis Ward January 30 2004 1:35 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Kline Hospice House Mount Airy
If Under 1 Year | If Under 24 Hrs. Frederick 8. Date of Birth
(Month, Day, Year)
March 22, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours 1 □ M 2 🖾 F 69 227-40-8366 1934 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. toside City Limits 1⊠Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 906 Rosemont Avenue 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roland Annis Lillian Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Ward / Husband 906 Rosemont Avenue Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3 February 1 Burial 2 □ Cremation 3 □ Removal from State 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Belle Haven Cemetery Belle Haven, Virginia 22. Name and Address of Facility Stauffer Funeral Homes, P.A 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASDICATION Due to (or as a consequence of) STAGE SCHSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FFMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No Other: 4 Nursing Home 5 Residence 6 BOther (Specify) HOSPICE 1 🗌 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier To certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 54749 01 30. Name and address of person who completed cause death (Item 23a) (Type, Print) House Ave, D-1, Frederick, MO 21701

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, page 2 should be detached signed by been To the Hospital or Attending Physician: funeral Director: After within 24 hours a To the Funeral D

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**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or itams 23s or 28s-1 show other traumatic event, the Medical Examples must be motified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: if item 27 is marked other than any injury or other traumatic event, the Menory injury or other traumatic event, the Menory injury or other traumatic event, the Menory injury or other traumatic event, the Menory injury or other traumatic event, the Menory injury or other traumatic event, the Menory injury or other traumatic event.

**Physician** 

**Examiner** 

attending physician

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Completed by Physician/Medical

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Certification: To

Medical

State Registrar 31. Date filed (Month, Day, Year) FEB 03 2004

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State of Maryland / Department of Health and Mental Hygiene 2 05379 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . Month Year **Physician** - WOOD WISE 6/6 PM tu gene 200 4 Lhvar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 ₹ M 2 □ F 204-28-0033 68 July 6, 1935 Pennsylvania Director Usual Residence of Decedent the Maryland 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28a-1 show any njury or other traumatic event, the Medical Examiner must be notified at once. 1√ Yes 2 No Director Franklin State Line 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17263 597 Redwood Drive Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 24 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Equipment/Supply 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles N. Wise Zelda Manahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 64 State Line, PA Deloris J. Wise/Wife 17263 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 2/9/2004 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rest Haven Funeral Chapel SIVande 1601 Pennsylvania Ave. Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician MM EDIATE /Medical Due to (or as a consequence of) Examiner MOCANDIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed 140CAN DIA and Due to (or as a consequence of) P.O. Box 68760, for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other signific≰n∜ conditions contributing to death but pet resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. pe 36-1 Tes 2 No 3 Probably 4 JUnknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 No 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 2 ER/Outpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ANatural 5 Pending Injury 1 🗀 Yes within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital Medical ( 29a. Certifier 1 🖵 🚅 tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signatur 29c. License numbe 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) METERVO mi 32. Pegistrar's Signature 31. Date filed (Month. State 6 Registrar

State of Maryland / Department of Health and Mental Hydiene

			1 - For State Registrar	State of Marylar	Cer	tificate of Dea	in and Mer ath	Reg.	ne 2004	05380
d	Physici		1. Decedent's Name (First, Middle, James R	Last) obert Witte					Day Year 31, 2004	3. Time of Death 0108 A M
	/Medic Examir		4a. Fecility Name (If not institution,			4b. City, Town, or Locati	tion of Death	THOM	4c. County of Death	0100 A
	Funeral Director		W/B WENTZ ROAD V 5. Social Security Number 213-04-1633	NEST OF RT 30 Sex 7. Age (In yrs. 23	last birthday) Yrs.	LINEBOR  If Under 1 Year If Un  Months Days Hou	nder 24 Hrs. 8	Date of Birth (Month, Day, Year)	CARROLL 9. Birthr Cour 1980 Mar	place (State or Foreign ntry) y l and
	n 72 hours after death with the Maryland "natural", or Items 23e or 28e-f ehow odical Exeminer must be notified an	Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Carre  10e. Street and Number  122 Grand Drive	011	ty, Town or Lo	Taneytow 10f. Zip Code 2178		10g.	Citizen of What Cour	10d. Inside City Limits 1 ☑Yes 2 ☐ No ntry?
-0036	hours after deati tural', or Items 2	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	Vas Decedent of Hispanic Yes, specify Cuban, Mex  Yes 2 No Specient's Usual Occupation			14. Race - Americ Black, White,	etc. hite
21215-0036	be filed within 72 ho stal Hygiene. od other than "natus event, the Modical	Completed	(Specify only highest (0-12) Elementary/Secondary (0-12) 12	grade completed) College (1-4or 5+)	(Give	kind of work done during in NOT use retired)  pe layer	most of working	100	constru	,
Maryland	ould be fill Mental Hy arked oth atic even	To Be	17. Father's Name <i>(First, Middle, La</i> James E. Witte			18. M	lother's Name <i>(Fi</i> Mary S		den Surname)	
	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other treumatic a <u>once.</u>		19a. Informant's Name/Relationship  James E. Witte/	father	122	g Address <i>(Street and Nu</i> Grand Dr.	Taneyto	wn, MD	21787	
Baitimore,	Pages 1 ment of H ant: If ital ury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	TRanscription Character	cemetery, cren	stion (Name of latory or other place) S Luth. Cem	Date 2/4/20		iontown, N	
Balt	permit. Page Department Important: If any injury or once.		21. Signature of Foneral Service Lic	O. Harteler	22	Name and Address of Fa 310 Church	nart	zler Fu w Winds	neral Home or, MD 217	76
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that caused the deat by one cause on each line.  Audity  a	. Inju	Ψ',	has cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
ú	, de cere	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a soneeq	painted off):					
68760,	tificate be executed by physician and as the burial-transit	edicai Exa	resulting in death) Last	Due to (or as a conseq	juence of):					
O. Box 6	the death cer y the attendir iched for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	il death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
rds, r	w requires that been signed b should be dete	þ	Part II. Other significant conditions	s contributing to death but not res	ulting in the un	derlying cause given in Pa	art I.	23e. Did tobacc	co use contribute to the	ne cause of death? ably 4 []Unknown
Vital Records,	The law ate has b page 2 sl	Completed						24a. Was an autopsy performed	prior to cor death?	psy findings available inpletion of cause of
lon of	ending Phy ath. or: After this ne funeral d	Certification: To Be	25. Was case referred to medical examiner?  1 X Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigat  3 Suicide 6 Could not determine	be gon Blace of Jaiver, At he	28b. Time of Injury	3 DOA Other: 4 28c. Injury at Work? M 1 Yes 2 et, factory, office	28d.	5 ☐ Residence Describe how in Vor of the Location (Street City or Town, St	or fixed	de which
	To the Hospital or Atti within 24 hours after de To the Funerel Directi completely filled in by the	ledical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time, date estigation, in my opinion,	e and place, and death occurred a	due to the cause	(s) and manner as st	ated
)	WJL	Me	29b. Signature and title of certifier	m.D		29c. License numb			Date signed (Month, INUARY 31,	Day, Year) 2004
	+10			nid	1 <u>1</u> 1 P	enn Street,	Baltimo	re, Mar	yland 2120	1
DH	Sta Registr MH 17 Rev 1/2	ar	31. Date filed (Month, Day, Year)	2 2004 <b>Registrar's Signa</b>		Goods				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra 004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Loretta Isabel Wood February 2004 9:20 p 1, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Long View Nursing Home Manchester Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2⋤F 100 Yrs 577-05-4105 Director 1904 Washington DC Jan 11 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other treumatic event, the Madical Examinar must be notified at Hampstead Carroll 1 ☐ Yes 2X No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2445 Snydersburg Road 21074 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No white þ Specify: Specify: 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife permit. Pages 1 and 2 should be fite Department of Health and Mental Hy Importent: If item 27 is marked other any injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Landonia Rebecca Scroggins Harry Bickerton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. Berglund, daughter 2445 Snydersburg Road, Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 02/05/2004 21. Signature of Furneral Service Licensee 22. Name and Address of Facility M90723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** M hours /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 No or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient examiner? Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₹No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Crtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 33165 ww 04 30. Name and address n/who completed cause of death (Item 2Ba) (Type, Print) Stew he Her 2111 4 anson 31. Date filed (Month, Day, Year) 32. Registear's Signature State Registrar

# Amended Items 23b, 23e, 24a per Physician 02/10/2004 Carroll County, wjl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 2, 1:35 p M Dorothy Lee Wickline 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 3540 Lowman Lane Union Bridge If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 18, 1934 Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7 Age (In vrs. last hirthday) **Funeral** Days Hours Min 1 ☐ M 2 🙀 F 220-30-5684 69 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral, or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√2 No Finksburg Carroll Director Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21048 USA 2241 Brown Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian. permit. Peges 1 and 2 should be filed within 72 hours after Deportment of Health and Mental Hygiene. Infortant: if item 27 is marked other then "natural", or itemportant: if item 27 is marked other then "natural", or itemportant or other traumatic event, the Medical Examinations. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: white þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Deli Clerk 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Beck John Gorman Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3540 Lowman Lane, Union Bridge, MD 21791 Kathleen A. Edmondson, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 02/06/2004 Evergreen Memorial Finksburg, MD 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility M00723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung cancer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No the detached 9 Unknown 9 Unknown ۵ signed 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No 2 X No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Daughters 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 715552 4.D.

31. Date filed (Month, Day, Year) State Registrar FEB 04

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2004

se of death (Item 23a) (Type, Pring) Street Westmisster, 41 21157 32. Registrar's Signature

		State of	i waryiand /	Certificate of	f Death	ентат пуу в	eg. No. 20 (	05383
	Physician	1. Decedent's Name (First, Middle, Last)			7.0	2. Date of Deet Month	Day Y	3. Time of Death
1	/Medical	ANDREW TYLER	-barl	WALTERS	JR 4b. City, Town, or Lo	JAN -	28,2004 4c. County of	
1	Examiner	4a Facility Name (If not institution, give street and num Salisbury Nursing and Re		er	Salisbury		Wicomi	
-	Funeral Director		7. Age (In yrs. last			8. Date of Birth (Month, Day June II		Birthplace (State or Foreign Country) Maryland
	0	Usual Residence of Decedent  10a. State 10b. County		own or Location				10d. Inside City Limits
	Mary Fresh	Maryland Wicomico	Sal	lisbury				1 ☐ Yes 2 🕱 No
	or 284	10e. Street end Number		10f. Zip Code		1	0g. Citizen of Wha	at Country?
	23a cast wi	1701 S. Mill Drive		2180			USA	
0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinar must be nettrad at page.  To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Dece Armed For 1 □ Yes, Giv Year or Decent Year or Decent Year or Decent Year or Decent Year or Decent Year or Decent Year or Decent	2 □XNo e ates:	1 □ Yes 2 <b>汉</b> N				American Indian, White, etc. White
5-6	natu dicel	15. Decedent's Education (Specify only highest grade completed)	10	<ol> <li>Decedent's Usual Occ (Give kind of work don life. DO NOT use reti</li> </ol>	upation e during most of working	ng	16b. Kind of Busin	ess/Industry
12	within sne.	Elementary/Secondary (0-12) College (1	-4or 5+)	owner	(60)		Fastener	Distributor
5	Hygi other ent, te	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, I	Maiden Sumame)	
ERS /lar	Menta Menta arriced	Andrew Tyler Walters Sr.			Elsie	Adkins	<b>S</b>	
MALTERS Maryland 21215-0020	nd 2 sho alth end I 27 is me ir traums	19a. Informant's Name/Relationship (Type, Print) Sharon Walters/wife	1	19b. Mailing Address (Stre 1701 S. M	et and Number or Rura ill Dr., Sā			
ANDREW WALTERS Baltimore, Marylan	Pages 1 a ment of He ant: if Item ury or othe	20a. Method of Disposition  1		of Disposition (Name of etery, crematory or other p Sons Cemeter	y 1,	/31/04	20c. Location - Cit Salisbu	ry, MD
AN	permit. Deperti	21. Signature of Funeral Service Licensee	(FSP					l Association 21804
		23a. Part1. Enter the disease, or complications that conshock, or heart failure. List only one cause on each	aused the death. Dach line.	Do not enter the mode of d	ying, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
9	Physician /Medical Examiner	Immediate Cause (Final disease or condition	aphulo co	ccus aure	us pran	nova		2 weeks
	<u> </u>	resulting in death)	Due to (or as	a consequence of):	,			
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ox 68760,		Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):				
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cords	ian: The lew requires that the death certificate has been signed by the attending octor, page 2 should be deteched for use es BE Completed by Physician/Me	Praleter mellitus				24a. Was a		4b. Were autopsy findings available prior to completion of cause of death?
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Division of Vital Records, P.O.	To the Hospital or Attending Physician: The lew within 24 hours efter death.  To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2.  Medical Certification: To Be Compl	3 Suicide 6 Could not be	of Injury - At home ng, etc. (Specify)	, farm, street, factory, offic		8f. Location (St. City or Town	reet and Number on, State)	or Rural Route Number,
	spital cours e neral C filled	29a. Certifier Certifying Physician: To the	best of my knowled	dge, death occurred at the	time, date and place. a	nd due to the ca	ause(s) and manne	er as stated.
	in 24 h in 24 h in 24 h pietely edica	(Check only 2 Medical Examiner: On the ba	sis of examination er stated.	and/or investigation, in my	opinion, death occurre	ed at the time, da	ate and place, and	due to the cause(s)
	To th To th comp	29b. Signature and title of certifier			nse number	2	9d. Date signed (A	Month, Day, Year)
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Mi	5 and	30. Name and address of person who completed causi	e of death (Item 23				1	
	State	31. Date filed (Month, Day, Year) 32. Re	egistrar's Signature			St.Suite	e,Salisbu	ry, Md.21804
	Registrar	FEB 0 2 2004	repeva	& sport	les .			

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registrar 05384 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 01 7:40 p<sup>M</sup> 1 ስ 2004 Wogu /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cheverly Prince Georges Prince Georges Hospital Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** 1 □ M 2 X F 86 11-30-1917 Umuahia, Nigeria Director 218-67-6119 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location rai, or itams 23a or 28a-f show Examinar must be notified at 1 X Yes 2 ☐ No Maryland | Prince Georges Bladensburg Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5217 Newton Street 20710 Nigeria within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black 3 X Widowed 4 □ Divorced natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical d 2 should be filed within the and Mental Hygiene. than. College (1-4or 5+) Elementary/Secondary (0-12) Self-Employed 12th Housewife 18. Mother's Name (First, Middle, Maiden Sumame) event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 9DGB. Be Adighuzo Njimogu Adighuzo Nwannediya ဥ 19b. Mailing Address (Street and Number or Ryral Royte Number, City or Town, State, Zip Code) 5217 Newton Street #104 19a. Informant's Name/Relationship (Type, Print) Chima Wogu/Daughter Bladensburg, Maryland, 20710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 03-07-04 Old-Umuahia, Nigeria Family Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3447 14th Street, N.W. Wash., D.C. 20010 Wanda Dacon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) in Motastases **Physician** 1ean /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year ŏ 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No P.0. the detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 99 2.X No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 ☐ Yes 2 😾 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatienl Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 📉 No 3 DOA 2 this in by the funeral 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 X Natural 1 □ Yes 2 □ No death. М 2 Accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 pellil within 24 hours a To the Funerel L 29a. Certifier 1K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 VANUARY 19 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul A DeVore MD 4203 Queensbury Road Hyattsville, Maryland, 20781 Paul A. DeVore, MD 31. Date filed (Month, Day, Year) FEB 0 2 2004 2. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05385 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Williams, Jr. Fred JANUAM 2004 /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b City Town or Location of Death Examiner Recd LANdover If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1934 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 69 226-34-4483 Director November 12. Usual Residence of Decedent the Maryland r 28e-f ahow 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 XYes 2 □ No Director Prince Georges Maryland Lanham 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ral', or items 23a or . Examiner must be r 3208 Reed Street, Apt. 2514 20706 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? June 1 X Yes 2 No 1951 If Yes, Give Year or DatesMarch 1953 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed traumatic avant, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Automobile Painter 12th grade Randall Body Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental marked Fred Williams, Sr. Mae Britt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Importent: If item 27 is any injury or other traited. James Lee Bynum (First Cousin) 4100 Maidstone Place; Fort Washington, Maryland 20744 20a. Method of Disposition

1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Dale 20c. Location - City or Town, State Feb.2,2004 Cheltenham, Maryland \* 4 □Donation 5 □ Other (Specify) Maryland Cheltenham Veterans Cemetery; P.G. County 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CArdio Manlo Hea Atheroscherotic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the all d be detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1☐ Yes 2 No Be 25. Was case reterred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification; 1 T Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours of To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbe 140055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SA (VAda 3001 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 0.2 2004 Registrar

_		1- For 2-10-04 Registrar Amend # 5. Per	State of Man	yland / Depa <i>Cer</i>	rtment of He	ealth and N Death	Mental Hyg	iene 2001	+ 05386
Physic	ian	Decedent's Name (First, Middle, Last, William					2. Date of Dear Month January	h	3. Time of Death 11:45 P M
/Med Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or l		1	4c. County of Dea	th
		Washington Advent: 5. Social Security Number 6. Se		n yrs. last birthday)	Takoma P	ark If Under 24 Hrs.	8 Date of Birth	Montgome	thplace (State or Foreign
Funeral Director		5 /0_30213EN	·	82 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) May 27,	1921 Sum	ountry)
land ow		Usual Residence of Decedent  10a. State  10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
e Mary 3a-f ah	ctor	District of Columb	ia V	Washington	n				1 XYes 2 No
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ē 2 2	by Funerai	11. Marital Status  1 Never Married **X**Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		Vas Decedent of His Yes, specify Cuban	panic Origin? (Sp., Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Am Black, Whi Specify: B1	te, etc.
Z 1 Z 1 S-UUSB d within 72 hours af giene. iv then "natural", or the Medical Exam	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	ent's Usual Occupat kind of work done du OO NOT use retired)	tion uring most of wor	king	16b. Kind of Business Cederal Gov	
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Saltimore, IN equit. Pages 1 and : partment of Health important: If Item 27 in y injury or other tr once.		20a. Method of Disposition 1. ☐ Burial 2 ☆ Cremation 3 ☐ F	Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place		Date	20c. Location - City or	Town, State
ESSITIMON  organic Pages 1  opariment of H  important; if its  any injury or ot once.		*4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Ligens		Lee's Cre		2/5 of FacilityRob		Clinton, M ason Funer	
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ob fou, icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or as a c	onsequence of):					
<b>68</b> / tificate tig phys	fedicai		d						
P.O. BOX 68/60, that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 2 [ 4□Pregnant at tirn 9□Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
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The The page	Completed	MEUINS, CLOST	RIDIUM DI	PFICLE (	POLITIS.		autops perforr 1 ☐ Yes	ned? prior to death?	completion of cause of : 2□ No
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DIVISION C al or Attending P after death. I Director: Atter i d in by the funers	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, stre Specify)	eet, factory, office		28f. Location (St City or Town	reet and Number or R. J. State)	ural Route Number,
Hospita 4 hours Funeral	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Madical Exami	sician: To the best of minar: On the basis of example and manner stated	amination and/or inv	occurred at the time estigation, in my opi	a, date and place, nion, death occur	, and due to the carred at the time, d	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier	robindi	$A \wedge c$	29c. License	number	2	9d. Date signed (Mont	0 ~1
(1)		30. Name and address of person who c	ompleted cause of-deat		Print)	124	i A	JUN JANU	1
<u> </u>	ate	31. Date filed (Month, Day, Year)	76WV IU/ 32 Registrar's	Signature	£1202, C	1000	ABUVA,	MO: 200	か
Regis		FEB 0 5 2004		K for	. A.C				

			1 - For State Registrar	tate of Maryland / Dep <i>Ce</i>	eartment of Health and Mertificate of Death	lental Hygien Reg. N	e 2004	05387
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	ay Year	3. Time of Death
	Physicia /Medic		MICHAEL	J. WATSON				9:44 AM
	Examin		4a. Facility Name (If not institution, give stree	t and number)	4b. City, Town, or Location of Death		c. County of Death	
			Howard County Gener	al Hospital	Columbia		Howard	
	Funeral		5. Social Security Number 6. Sex  ★□ M	7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea	9. Birthplac Country	e (State or Foreign
	Director		577-96-0807	31 Yrs.		May 29, 19	972 Was	sh., DC.
	pu s		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		10d	. Inside City Limits
	sho	ក		7.7	-1			1 Tyes 2 □ No
	288-1	ect	D.C	Wa	shington 10f. Zip Code	10g. C	Citizen of What Country	1?
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	ns 23	era	11 Marital Status 12. V	<u> </u>	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American	Indian,
10	r Iten	Funeral Director	1 ☐ Never Married 2 ☒ Married	☐Yes 2 XNo		Rican, etc.)	Black, White, etc	2.
93	el', o	þ	3 ☐ Widowed 4 ☐ Divorced	f Yes, Give Year or Dates:	1 ☐ Yes 2 【XNO Specify:		Specify: Bla	ıck
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21	ithin	npte	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		26	
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ug	tal H d off	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maide		
Z	ould Men narke	<sup>2</sup>	Clark D. Watson	Onical 40h Mai	ling Address (Street and Number or Ru	rolyn Kelly		adal
Maryland	12 sh h and 7 is n traun		19a. Informant's Name/Relationship (Type,					ode)
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I important: If item 27 is marked other than "naturel; or Items 23a or 28a-f show any injury or other traumatic event, the Maulical Examinal must be multiled at ance.		Carolyn G. Kelly/Mo	20b. Place of Disc	Steel St. San For		28327 Location - City or Town	n, State
آور	nt of Interest		1 ₺ Burial 2 ☐ Cremation 3 ☐ Remo	oval from State	ematory or other place)	3-04	Landover,	Md
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7	Physician /Medical	1	disease or condition resulting in death)	Due to (or as a consequence of):	- Jack Cat			
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	4	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of).				
	cuted od ransit	Examin	Cause (Disease or injury that initiated events c.					
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Вох	death certific e attending p d for use as	an/	23b. Was decedent pregnant		□Ectopic pregnancy		23d. Date of delivery Month Da	ay Year
0.	the dea y the a	Physician/M	1 Ves 2 No	4□ Pregnant at time of death 5 9□ Unknown	Other (specify)			
<u>a</u>	a o	Ph	Part II. Other significant conditions contrib	uting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the	cause of death?
Records,	se og	d by		•		1 🗌 Yes	2 D o 3 □ Probab	ly 4 ∐Unknown
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3ec	e lav	Completed				autopsy performed?	death?	y findings available letion of cause of
a	_ a □		25. Was case referred to medical		OC Place of Page	th (Check only one)	No 1/0 Yes 21	□ No
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Division	Attendi r death. ector: A by the fu	ifica	STRUMENT STROUGHT not be -	86. Place of Injury - At home, farm, s	street, factory, office	28f. Location (Street :	and Number or Rural R	Route Number,
ā	el or s afte ol Dir	Certification:	4 - Homede	building, etc. (Specify)	EET	8400 101	rsey Kan	KD.
	• Hospitel or Attent 24 hours after death • Funerel Director: etely filled in by the				ath occurred at the time, date and place investigation, in my opinion, death occu			
	To the Hospitel or Atta within 24 hours after de To the Funerel Directo Completely filled in by th	ledicai	one	and manner stated.				
	To T	Σ	29b. Signature and title of certifier	1	29c. License number		Date signed (Month, Da	
	(1)		1 Clocket	W)	O.C.M.E.	Jan	uary 23, 20	004
0	104		30. Name and address of person who comp	leted cause of death (Item 23a) (Type	Print) Penn Street, Balt	imoro Mor	viland 2120	1
1		lis	31. Date filed (Month, Day, Year)	32. Registrar's Signature	- Lan Direct, Dall	HINTE, LIGIT	Y TOIRL ZIZU	<b>.</b>
	St. Regist	ate rar	FER 0 5 2004	Kens & Chas	h)			

05388

4:57AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1X□Yes 2□No

Queens, NY

**Black** 

20706

20011

Day

Year

Approximate Interval Between Onset and Death

State of Maryland	Certificate of Death	Reg. No. 2004	0538
nt's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
s Ann Williams-Bland		February Day, 2004	4:334

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician
/Medical
Examiner

11)/LL(Ams

Examiner ng physician and as the burial-transit The law requires that the death certificate be executed Box 68760. nse : jo P.O. 1 signed b Records, page Division of Vital this After death. in by

Dori: 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Doctors Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🛣 F 48 577-76-1001 Yrs. 03/31/1955 Director Usual Residence of Decedent 10c. City. Town or Location the Maryland 10a. State 10b. County 28a-1 show other traumatic event, the Medical Examiner must be notified at MD Prince George's Lanham Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or itama 23a or 20706 USA 9909 Greenbelt Road #201 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 72 hours after 1 ☐ Never Married 2 € Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced "natural". Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, It a Medic once. College (1-4or 5+) Elementary/Secondary (0-12) Supervisor, Medical Records P.G. Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) David Williams Richardine Graham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 9909 Greenbelt Road #201 Norman L. Bland, Sr. - husband Lanham, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Baltimore, Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial 2/7/2004 Landover, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Tyrone J. Young Funeral Services 719 Kennedy Street, NW Wash., DC 23a. Part1. Exter the disease, or comply shock, or leart failure. List only on not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irjun) that initiated events resulting in death) Last Physician/Medical Examiner 10 Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 menths? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 EN/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner states 29d, Date signed (Month, Day, Year) 29b. Signature, and title of certifier 29c. License number 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOVELL RD CHENERLY

State

Registrar

MARGAKET 31. Date filed (Month, Day, Year)

FEB 0 5 2004

6148

2. Registrar's Signature

			For 1 - State Registrar	State of Maryla	and / Depa <i>Cer</i>	irtment of F <i>tificate of</i>	tealth and <i>Death</i>	l Mental Hy	giene , Reg. No. 4	2004	05389
			Decedent's Name (First, Middle, Last)					2. Date of De	nath Day	Yeer	3. Time of Death
	Physici /Medic		Christine	Gill	W€	1ch		1 3		004	13:45 P <sup>M</sup>
	Examin		4e. Fecility Name (If not institution, give str			4b. City, Town, o	or Location of De	ath	4c. Co	ounty of Deeth	
			Prince George's  5. Social Security Number 6. Sex		rs. last birthday)	Ch If Under 1 Year	ever1y	rs. 8. Date of Bir	P		George's
Н	Funeral Director			1 2F 6		Months Days	Hours Mi	n. (Month, Da	1935	Nor	place (Stete or Foreign intry) th Carolina
	79.75		Usual Residence of Decedent						1,555	1101	ch Carolina
	how		10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
	e Ma	Director	DC		Washingt						1½ Yes 2 No
	or 24	Dire	10e. Street and Number			10f. Zip Code			_	n of What Cou	intry?
	a 23a	rai	800 Southern Ave	nue S.E.  Was Decedent Ever in	110 112 1	20032	tion and Onlain?	(C		S.A. Race - Amer	iana Indian
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other then "netural", or itema 23a or 28a-f ehow event, the Medical Exertiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cub:	Specify:	(Specify Yes or No erto Rican, etc.)		Black, White	
Ö	72 ho	Completed	15. Decedent's Educa (Specify only highest grade of		16a. Deced	ent's Usual Occup	pation during most of w	varkina	16b. Kind	of Business/Ir	ndustry
2	- 10	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	d)	.oing			
2	filed withi Hygiene. other then	S		4	Exec	utive As				rnment	
Maryland	ould be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle, Last) Wilson	Gill				<sub>ame (First, Middle</sub> nerine B1		imame)	
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<u>8</u>	nd 2 s Ith an 27 is		Juan Dunlap,								n, DC 20032
ē,	s 1 ar f Hea f tam other		20a. Method of Disposition	206		sition (Name of natory or other place		Date		tion - City or T	
Ë	Page: ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer 1 ☑ Donation 5 ☐ Other (Specify)	novar ironi State		tion Cem		9-2004	C1in	ton,Man	cvland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic ex ance.		21. Signature of Funeral Service Licensee	00	22	Name and Addre	ss of Facility	J. B. Jei ad Lando	nkins	Funer	al Home
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the de	eath. Do not ente	er the mode of dyir	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Acute Myocardial Infarction								
	/Medical		resulting in death)  Due to (or as a consequence of):								
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	D #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a cons							
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Diabetes Due to (or as a cons		18				$\rightarrow$	
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58760,	ficate be executed physician and s the burial-transit	dicai	d								
P.O. Box (	death certi e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year			
	The law requires that the site has been signed by the bage 2 should be detache	y Ph	Part II. Other significant conditions contri	buting to death but not r	esulting in the ur	iderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to	he cause of death?
rds	quires tha n signed uld be del	d by	Cerebral Vascul	ar Disease				10	Yes 2□!	No 3□Pro	bably 4 KjUnknown
<u>o</u>	ıw requir s been si should	Completed	Congestive Hear	t Failure				24a. Was		24b. Were aut	opsy findings available
æ	The lay	Шо	Hypertension					autor perfo	osy ormed? 2 No	prior to co death? 1  Yes	ompletion of cause of 2
a	icien: Th	Ø.	25. Was case referred to medical				26. Place of D	eath (Check only		10.00	
<b>&gt;</b>	d is	To B	examiner? 1 ☐ Yes 2 No		ER/Outpatien	3□ DOA Oth	er: 4 🗍 Nursing	Home 5 ☐ Resi	dence 6	Other (Speci	(y)
0	ding Ph J. After th funeral	on:	27. Manner of Death 1   Matural 5 □ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe			
Division of Vital Records,	Attending Physicien: or death. rector: After this certification by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be	DO - Discontinuo A	h to		Yes 2 □ No	2006 Lauretina (	C44		
$\frac{1}{2}$	2 4 5 6	ertif	4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe		et, ractory, office		City or To		umber or Hur	al Route Number,
_	To the Hospital or within 24 hours afte To the Funeral Dis completely filled in		29a. Certifier 1 Certifying Physic	ian: To the best of my k	nowledge, death	occurred at the tir	ne, date and pia	ce, and due to the	cause(s) an	d manner as s	stated
	Ho 124 h Fur letely	Medicai	(Check only 2 Medical Examine one)	r: On the basis of examinand manner stated.	ination and/or inv	estigation, in my o	pinion, death oc	curred at the time,	date and pla	ace, and due t	o the cause(s)
	To the Hospital of within 24 hours af To the Funeral D completely filled in	2	29b. Signature and little of certifier	11) m	)	29c. Licens	e number		29d. Date s	igned (Month,	Day, Year)
•			Farmon to	Low	/	D31	173		2,	3/04	
R	(10)		30. Name and address of person who com			Print)				-	2
_	1'/		Raymon Nelson M.			reet N. 1	E. Washi	ngton, D	C 200	)17	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 6 2004	32. Registrar's Sig	Speed	U					

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

4			1 - State Registrar Unpend It  1. Decedent's Name (First, Middle, Las	Cm , 2 3 a , 2	7,28a-	Cer	tificate Fof	Death, 3/	8/04eg	Reg. N	۰.	U 4	U539	
	Physici		Month Day Year										M	
	/Media		SANDRA MA  4a. Facility Name (If not institution, give		Y		4b. City Town	or Location of Dea			. 2004 c. County o	of Dest	5:10 a	
	Examir	er	PRINCE GEORGE'S HO		מידידי				u i		,			
	Euperel	-	5. Social Security Number 6. Se		NIER (In yrs. last birt	(hday)	CHEVER If Under 1 Year	If Under 24 Hrs		rth	RINCE		RGE 'S lace (State or Fore	eign
*	Funeral Director			1□ M 20XF Yrs.			Months Days	Hours Min		a <i>y</i> , Year	7	Coun	try)	21911
	P _		Usual Residence of Decedent				1		reb.		T20/	wasn	· U.U.	
	thow	_											0d. Inside City Lim	
	Sa-1 s	Director	D.C.		Washin	gto	n						1X Yes 2□	No
	ith th	Dire	10e. Street and Number				10f. Zip Code				itizen of W	hat Coun	try?	
	ath w	rai	316 62nd St., N.				20019				·S.A.			
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23a or 28a-f show aumatic event, the Mudical Examinar must be notified at	by Funerai	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent B Armed Forces?  1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			/as Decedent of H Yes, specify Cuba ☐ Yes 257 No	dispanic Origin? () an, Mexican, Puel Specify:	Specify Yes or N rto Rican, etc.)	0-		, White,		
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<u>a</u>	fental rked c	To E	James Worthy Jr.					Incenh	ine_Jone					
a	should and Men a marke umatic	-	19a. Informant's Name/Relationship (7	ype, Print)	19b.	Mailing	Address (Street	and Number or R			or Town, S	tate, Zip	Code)	
Σ	and 2 ealth a m 27 ly		Robin Coleman/Sis	ter	3	16	62nd St.	, N.E. #	102 Week	. 10	C 2	nnta		
timore,	of H of H r oti		20a. Method of Disposition		20b. Place of	Dispos	ition (Name of atory or other place		Date	20c. L	ocation - C	ity or To	wn, State	
Pages	Pag nent ant: I	7 1	Burial 2 Cremation 3 Removal from State of Donation 5 Other (Specify)  Glenwood Cem. 2/11/04  Wash. D.C.									C.		
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			23a. Part 1. Enter the disease, or coro	lications that caused	the death. Do n	-							Approximate	
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è	/Medical		disease or condition resulting in death)	a. IHCOX	consequence of	1 .	omplica	ting h	ypother	rmia	1			
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-	ng as		IF FEMALE:											
ô	The law requires that the death ce ite has been signed by the attendir page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth	2 Fetal death		Ectopic pregnancy	,			23d. Date Mont		ry Day Year	
	the a	/sic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at: 9□Unknown	time of death	5 🗌	Other (specify)				1410116		Day Toal	
P.O.	res that the de signed by the a be detached f	Ph	Part II. Dther significant conditions co	ontributing to death bu	t not resulting in	the un	dorhving oguso gu	on in Part I	220 Did	obassa			e cause of death?	-
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ě	has in has ige 2 s	Completed							24a. Was	psy	pri	or to com	sy findings availal opletion of cause of	ble of
e										ormed? 2□ No	1)	ath? Yes	2□ No	
=	Attending Physiclan: r death. ector: After this certifict by the funeral director.	Be	25. Was case referred to medical examiner?	Hospital:			Oth		ath (Check only					
ō	Phys	. To	1  Yes 2 No 27. Manner of Death	1 ☐ Inpatier			3 DOA Oth	er: 4 🗆 Nursing l	dome 5 Res	dence	6 Other	(Specify,	)	
UC	After funer	lon	1 □Natural 5 □ Pending	found Day	Year) f b	מישוי			28d. Describe		iry occurred	d		
<u>s</u>	death death stor: / the	Certification:	2 Accident investigation 3 Suicide 6 X Could not be	1/31/0		. : 0 (	J P	Yes 2 No	unkno				2	
Division of Vital Records,	Diff.	ertii	4 Homicide determined	28e. Place of Inju building, etc	(Specify) near r				City or To	wn, State	e)		Route Number,	
_	Hospital Puneral Hospital		29a. Certifier 1☐ Certifying Phy	sician: To the best o				ne date and place	Baltim	ore	XHD C	. , N	ortheas	C
	24 h	edical	(Check only one) Medical Exam	iner: On the basis of and manner star	examination and	Vor inve	estigation, in my o	pinion, death occi	urred at the time,	date an	d place, an	ner as sta d due to	the cause(s)	
	To the Hospital within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier	// // // // // // // // // // // // //			29c. Licens	e number		29d. Da	ite signed (	Month, D	Day, Year)	
	F > F 0		12.1. 5.11.1	1 AS			OCI	Œ			JARY 2			
11			30. Name and address of person who c	ompleted cause of de	ath (Item 23a) (	Type P	rint)					, =00	-1100010000	Tests
_			2ABILI LLAH	ALI	(nom £0a) (			Street, 1	Raltimo~	<b>20 1</b>	(a	mel 1	21201	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature			Jucely 1	TOHEL	C, P	лату	DIJU &	Z 1 Z U 1	
A	Registr	_	FFR 1 1 2004	Black	K. Ash	30/2	/							

Reuben C. Watson 04-

RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		1. Decedent's Name (First, Middle, I	ast)					2. Date of De Month	ath Day	Yea	3. Time of Death
hysici		REUBEN	CLARENCE	WATSO	NC	III		Januar		, 2004	
Medio xamir		4a. Facility Name (If not institution, g Peninsula Regio				4b. City, Town, o	r Location of D		4c.	County of De Wicomi	ath
neral ector		217-54-5894		ge (In yrs. last b 4	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bin Min. (Month, Da November			irthplace (State or Fore Country) laryland
show ed at	Į.	Usual Residence of Decedent  10a. State 10b. County		10c. City, To							10d. Inside City Lim
or 28a-f	Funeral Director	Maryland Wicomi  10e. Street and Number		Marc	dela	Springs 10f. Zip Code 2183	07		10g. Citi	zen of What (	
8 23e	ral	23669 Ocean Ga		Fire in II C	12.14			2 (50004) Van an Na		USA	anian Indian
Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Examinat must be notified at single.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【XDivorced	12. Was Decedent Armed Forces  1	?	1	vas Decedent of H Yes, specify Cuba ☐ Yes 2 1 No		? (Specify Yes or No uerto Rican, etc.)		Black, Wh	nerican Indian, nite, etc. white
Madical	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)			(Give I	ent's Usual Occup kind of work done OO NOT use retired	during most of	working		nd of Busines	,
1	Com	12	_		Carpe	enter			Home	Impro	ovement
event,	Be	17. Father's Name (First, Middle, La						Name (First, Middle,		Sumame)	
atic	ို	Reuben Clarenc						abeth Hea			
1 Z/ 15 III er traum		19a. Informant's Name/Relationship Janice W. Adam		19				r Rural Route Numbe Salisbury,	-		, Zip Code)
ry or oth		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation 3 1 □ Donation 5 □ Other (Spe		cemet	lery, crem	sition (Name of latory or other place Cremato:		Date 30/04		cation - City o isbury	or Town, State
Importent; if item 27 is eny injury or other tra since.		2 signature of Funeral Service Lic	ensee	FSP	F	Name and Addre	Funera.	l Home Pro	fess	sional	Associatio
sician edical miner		23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ly one cause on each I  Hypothem  a	line.		er the mode of dyin	ig, such as car	diac or respiratory ai	rest,		Approximate Interval Between Onset and Death
attending physicien and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a consequence							
ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)			2	23d. Date of d Month	elivery Day Year
9 9	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of 1 Yes 2 No 3 Probably 4 !		
oertificate has been signed by the attending physicien and ector, page 2 should be detached for use as the burial-transit	Completed							24a. Was autop perfo 1 XYes	sy rmed?	24b. Were a prior to death?	
this certifi al director	To Be	25. Was case referred to medical examiner? 1∑ Yes 2 □ No	Hospital: 1 ☐ Inpati	ient 2 🗷 ER/C	Dutpatient	3 DOA Oth		Death <i>(Check only o</i>		Other (Sp	eecify)
To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification:	27. Manner of Death    Natural   5						28d. Describe for Unknown  28f. Location (S	Street and	d Number or i	Rural Route Number, irdela Spring
unerel	Medical C	29a. Certifier 1 Certifying (Check only one) Medical Ex	Physicien: To the best eminer: On the basis of and manner st	of examination a	ge, death and/or inv	occurred at the tinestigation, in my o	ne, date and p pinion, death o	ace, and due to the courred at the time.	cause(s) date and	and manner a	as stated. ue to the cause(s)
F 96	l ŏ	(Check only one)  Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, are and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed							29d. Date	sinned (Mo)	nth, Day, Year)
ro the F complete	Σ	29b. Signature and title of certifier	100			200. 2100113	0 110111001			o organica (mior	nin, buy, reary

			1 - For State Registrar	State of I	Marylan		artmen tificat			and Me		iene	Ω L	05392
	Physici	ian	1. Decedent's Name (First, Middle, Li Helen T. Wells	ast)							Date of Deat Month	Day	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, gi	ve street and numbe	er)		Jan. 26, 2004  4b. City, Town, or Location of Death  4c. County o					of Death	12:22 P.M	
			5007 Harmony Lane					ow H				Worcester		
j	Funeral Director		5. Social Security Number    215-16-8053		If Under Months	1 Year Days	If Under 2 Hours		8. Date of Birth ( <i>Month</i> , Day 5 / 30 / 19	9. Birthplace (State or Forei Country) Maryland				
			Usual Residence of Decedent		10.00									
	Aaryla f shov	ō	10a. State 10b. County Worces	ter	10c. Cit	y, Town or Lo Snow	cation 7 Hill	1						10d. Inside City Limits 1 ☐ Yes 2√☐ No
	n the h	irect	MD WORCES  10e. Street and Number				10f. Zip	Code			19	Og. Citizen of V	/hat Cou	ntry?
	ath wit	ral D	5002 Harmony Lan	е				218	363			US.	A	
920	ilied within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or Items 23a or 28e-f show ont, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Yes 22 If Yes, Give Year or Date	s? ∑No	1	Vas Deced Yes, spec			gin? (Spec , Puerto R	cify Yes or No- lican, etc.)	Blac	- Americk, White,	
2-0	"naturel", or	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	kind of wor	rk done di	urina most	of working	a l	16b. Kind of Bu	siness/In	dustry
Maryland 21215-0036	be filed within 72 ho ttal Hygiene. Ind other than "natur event, the Michal	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. L	oo not us istre:	se retired)				Garmen	t Fac	ctory
ם ב	be filed withis tal Hygiene. d other than event, Ite M	BeC	17. Father's Name (First, Middle, Las	")		Dean			18. Mother	r's Name (	(First, Middle, N	faiden Surnam	e)	
ylar		ToE	George Taylor								adford			
Mar	is 1 and 2 should of Health and Me Itam 27 Is mark other traumatic		19a. Informant's Name/Relationship Debbie S. Wells,		In Ia		-				Route Number,  OW Hill			
re,	is 1 and Heal		20a. Method of Disposition		20b. P	lace of Dispos	sition (Nam	ne of		Da	ite 2	Oc. Location -		
imo	Pages ment of ant: If it ury or o		1 N Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci		sper	nce Bap	tist	Chui	ch C	em.01/	29/04	Snow 1	Hill:	, MD
Baltimore,	permit. Pages Department of H Important: If Its eny injury or of once.		21. Signature of Funeral Service Lice			22.	Name and	d Address	of Facility	/ Iomo	Tno			
ī	20200		23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caus	ed the death	1. Do not ente	3 E.	Grov e of dying	e St.	Del:	mar, De	. 19940		Approximate
	hysician		shock, or heart tallure. List only Immediate Cause (Final disease or condition	The cause on each	Iline.	CF	-41	LU	RE	-				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	uence of):								
		er	Sequentially list conditions, if any, leading to immediate	0	as a consequ								-	
	icate be executed physicien and s the burial-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	o. Her	PAT	(Els	<	-						
8760,	be exe		resulting in death) Last	Due to (or a	as a consequ	uence of):								
687	ficate physics the l	edical		d						-				
Вох	death certificate be execut e attending physicien and id for use as the burial-trar	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pre	anancy				23d. Date		
		yslci	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of de		Other (spe		_			Mon	th	Day Year
, P.O.	law requires that the dass been signed by the 2 should be detached		Part II. Other significent conditions	contributing to death	but not resu	ılting in the un	derlying ca	use giver	in Part I.		23e. Did toba	acco use contri	bute to th	e cause of death?
Vital Records,	v requires been signi should be	Completed by			**						1 🗆 Yes	2 500	3 🗌 Prob	ably 4 Unknown
Seco.	e 2 sh	nple								_	24a. Was an autopsy	pr	ior to cor	osy findings available npletion of cause of
la l	ysicion: The lav is certificate has director, page 2	e Cor	25. Was case referred to medical									No 11	eath?	2 No
<u> </u>	S 2 5	To Be	examiner?	Hospital: 1 ☐ Inpa	tient 2 🗆 f	ER/Outpatient	3 🗆 DO/	Other		of Death (	Check only one	ice 6 Other	(Specify	()
0 [	Ing Phys Itter this Ineral di		27. Manner of Death 1. ☑Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time of Injury		3c. Injury a Work?	at		d. Describe hov			/
Division of	Attending r death. ector: After by the fune	cat	2 Accident investigatio 3 Suicide 6 Could not b	e One Place of I	niuny - At ho	me farm stre	M et factors		es 2 N		f Location /Stre	eat and Alumba	r or Puro	l Route Number,
<u>`</u>	s after s after si Dire	Certification;	4 Homicide determined	building,	etc. (Specify	)	ei, 120101y,	omea		201	City or Town,		or nura	r House Warnber,
:	To the nospital or Attending Priving P	edical	29a. Certifying Pt (Check only one) 1 Sertifying Pt 2 Medicel Exam	nysicien: To the bes niner: On the basis and manner:	of examinati	viedge, death ion and/or inve	occurred a estigation,	it the time in my opii	, date and nion, death	place, and occurred	d due to the cau at the time, dat	ise(s) and man e and place, ar	ner as stand due to	ated. the cause(s)
	vithin 2 To the	Σ	29b. Signature and title of certifier	11,			29c.	License	number		290	d. Date signed	(Month, L	Dey, Year)
		-	36 Name and address of person who	completed sarse of	death (Item	23a) (Type 🛚	rint)	124	87	2		128/	04	<u> </u>
UD	3		PAUL R FLEW	IRY 5	205	Tent	4 5	T	1200	on	oke (	SIZ	ME	021891
	Sta Registr	_	31. Date filed (Month, Day, Year)  JAN 2 8 2	32. Regis	trar's Signat	ure &	Sp	aks	/					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** WATTERS 9, BESSIE TROUT Feb. 2004 6:30 PM /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3736 Norrisville Road Jarrettsville Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 2/27/191 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K F Months Hours Days Yrs. 217-74-4613 90 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be nutilled at 1 ☐ Yes 2 No Director MD. Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 3736 Norrisville Road 21084 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 💢 No Specify: \* Specify: 3 XWidowed 4 □ Divorced Year or Dates: White "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 9 Housewife 0 Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Purd Trout Mabel Kilgore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 084 19a, Informant's Name/Relationship (Type, Print) 3634 Anderson Joan W. Dorn /Daughter Lane Jarrettsville. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o once. 1 ABurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Jarrettsville Cem. 2/12/2004 Jarrettsville, Md 21. Signature of Furieral Service Licenses permit. 22. Name and Address of Facility Jarrettsville, Maryland Kurtz & Son Funeral Home, P.A. E.G. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Myocardial **Physician** 1x hours resulting in death) /Medical Due to (or as a consequence of): Examiner ORNAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Examiner physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ◯ No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 Marketines 6 | Other (Specify, 1 Tes 2 No ို 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Aftert 1 Natural 5 Pending Injury To the muserus.

within 24 hours after death.

To the Funeral Director: All 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Be/ Ar MD 21014 ny der mi) 4 HICKON ARE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For AMENDED #27 004 State RegistraWCHD/SH 2/9/04 per Dr. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** EBRUAL 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTI MOLE CI If Under 1 Year If Under 24 Hrs. Months Days Hours Min. POPKINS JUHN. Altimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2□ F Director 204-30-7681 04 INIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or itema 23a or 28a-f shov other traumatic svent, the Medical Exertible 1. 1 ☐ Yes 2 No Director oceden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1722 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2. No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TACKINE OperAtor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If ite tmportant: If it any injury or o once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee MAGERSTOWN, MD. uclo of Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAE **Physician** MINHTE /Medical Due to (or as a consequence of): Examiner NEMIA 6 Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant al lime of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) P.O. I 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 4 DUnknown 1 Tyes 2 🗌 No 3 Probably funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Anatural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After nvestigation М 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Garrett Lasalle WOLFE STREET, BALTIMORE, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

FEB 0

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State of Maryland / Department of Health and Mental Hygiene 2004 05395 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 26, Jan. 2004 7:00 a Harry Dusty Zucker /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/24/1944 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 59 Yrs San Francisco, Director 577-58-8545 Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show the Madical Examiner must be notified at 1X Yes 2 No Silver Spring MD Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20910 USA 8510 Milford Avenue Ітеть 23а Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: hours after 1 Never Married 2 Married 0 Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White δ 3 ☐ Widowed 4 ☑ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education 72 (Specify only highest grade completed) within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Proprietor Pet Shop Owner Ith and Mental Hygie 27 is marked other ti 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be f nd Mental I Barnet Zucker 2 Evelyn R. Cohn 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n sny injury or other traum Evelyn R. Zucker - Mother 8510 Milford Avenue, Silver Spring, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 1/29/04 Alexandria, VA \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Gasch's F.H. 4739 Baltimore Avenue landette 20781 Hyattsville, MD Xanning 2)ax 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Sudden -Physician /Medical Due to (or as a consequence of). Examiner Coronary Artery Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of) Examiner certificate be executed Diabetes Mellitus Years the burial-tran and resulting in death) Last Due to (or as a consequence of) Box 68760, physician by Physician/Medical attending for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Dunknown End stage renal disease Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No Hypertension has page 5 1 Yes 2 No of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 2 ☐ ER/Outpatient 3 ☑ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Division 5 Pending 1 🛭 Naturai after death.

I Director: Af of in by the fu 1 ☐ Yes 2 ☐ No investigation 2 🗌 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled i 1🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only he 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D32332 1/26/04 111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Ave, Ste 220, Silver Spring, MD 20902 Suresh K. Gupta 31. Date filed (Month, Day, Year) State 0 2 2004

DHMH 17 Rev 1/2001

Registrar

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 8 per the 845 7-15-05 dnb.

Amend Item 8 per the 845 7-15-05 dnb.

			For State Resistant Amond Trem#20	State of Maryland / bperFHG8282/24/04 EW	Department of Health and i Certificate of Death	Mental Hygler Reg. f	2004	05396
- 360	Physici	10	Decedent's Name (First, Middle, La	ist) A		2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic	al	EMILY 4a. Facility Name (If not institution, gir	HSSANA N ve street and number)	4b. City, Town, or Location of Deat	Februar	Y 17, 2004 4c. County of Death	11.121.
	Examin	er	Stella Maris	Hospice	Timonlum	10.00	Baltim	ore Co.
	Funeral Director		216-94-7838	Sex 7. Age (In yrs. last b.	rthday) If Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes Jan. 22, 192	22 Guya	ace (State or Foreign and, S.A.
	the Maryland 28e-f show	tor	Usual Residence of Decedent  10a. State  10b. County  Baltin	nore Co. Perr	vn or Location		10	od. Inside City Limits 1 ☐ Yes 2 ☑ No
	death with the Maryland ms 23e or 28e-f show	Funeral Director	10e. Street and Number	nor Court	10f. Zip Code 2/128	10g.	Citizen of What Count	ry?
5-0036	or Ite	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Tyes 2 Tho Specify:	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e Specify: Black	
1215-0	within 72 hours jiene. ir than "naturel", I'ne Medical Ex.	Completed	15. Decedent's Elementary/Secondary (0-12)		a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)  HIMP	rking 16b	Kind of Business/Ind	,
and 2	A E L M	To Be Co	17. Father's Name (First, Middle, Las	erali	1,01.10	me (First, Middle, Maid		
Maryland	s 1 and 2 should be filed Health and Mental Hyg tem 27 is marked othe other treumatic event,	Ţ	19a. Informant's Name/Relationship	Type, Print) (Son) 19	b. Mailing Address (Street and Number or R	ural Rouse Number, Cit	y or Town, State, Zip	Code) ), 21/28
Baltimore,	0 = 0		20a. Method of Disposition  18 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	allevial Com	3/2004	Location - City or Ton	MD.
Balti	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Lice	J. Jan er	2325 YOCK FA		neral offren	water Center 21093
	Physician /Medical		23a. Part . They the disease, or co- shock, or reart failure. List oni tmmediate Cause (Final disease or condition resulting in death)	mplications that caused the death. Do y one cause on each line.  a. BLADDER CANCE  Due to (or as a consequence		c or respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	_	Sequentially list conditions, if any, leading to immediate	b				
,0,	icate be executed physician and s the burial-transit	Examiner	ran, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c				
68760,	icate phys	edical		d				
. Box	Attending Physician: The law requires that the death certif refeath. sector: Alter this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ry Day Year
ds, P.0	w requires that the desbeen signed by the a should be detached to	by		contributing to death but not resulting	in the underlying cause given in Part I.		co use contribute to the	
Division of Vital Records,	The law rec ate has bee page 2 shou	Completed				24a. Was an autopsy performed 1 ☐ Yes 2 😿	prior to cor death?	osy findings available inpletion of cause of
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	eath (Check only one)	0.5500000000000000000000000000000000000	HOGDIGE
on of	ding Phys h. After this funeral did	tlon: To	1 Yes 2X No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year) 28b	Dutpatient 3   DOA   Outside   4   Nursing	Home 5 Residence 28d. Describe how i		HOSPICE
Divisi	of or Atten after deat Director: d in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	be 290 Pinco of Injury At home	farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 Certifying 2 Medicel Ex	Physicien: To the best of my knowled aminer: On the basis of examination and manner stated.	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occurred.	curred at the time, date	and place, and due to	the cause(s)
	To the within 2 To the complete	M	29b. Signature and title of certifier		29c. License number		Date signed (Month,	Day, Year)
	M		30. Name and address of person wh	no completed cause of death (Item 23a			0/18/0	7
_	10		DR. TARIQ MAH	MOOD 2300 DULANE	Y VALLEY RD. TIMONIU	M, MD 21093	}	
€	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 0 2004	32. Registrar's Signature	Sporter			

DHMH 17 Rev 1/2001

Registrar

11:15 р.т.

FEBRUARY 17, 2004

EMILY ASSANAH

State of Maryland / Department of Health and Mental Hygien 🗗 🏻 🗓 👢 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Ernest S. Arndt, Jr. February 17, 18:50 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Med. Cen. Baltimore City N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08/20/1946 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 218-44-2403 1**反** M 2□ F 57 Souin*try)* MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any finray or other traumatic event, the Medical Examinar must be natified at any injury or other traumatic event, the Medical Examinar must be natified at angles. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD N/A 1 Yes 2 □ No Baltimore City Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1825 Ramsay Street 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 0 Factory Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last)
Trnest S. Arndt, Sr. Anna May Triner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shirley Hedges / Sister 1829 Ramsay Street, Baltimore MD 21223 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Cedar Hill Cem. Feb. 20, 2004 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Maryland ^ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final CARRICEN 10116 Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 8 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐XNo 1 ☐ Yes 2√2 No Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral dir 2 1 ☐ Yes 2xxNo npatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1XXVatural 1 ☐ Yes 2 ☐ No death. М 2 Accident Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Thomicide 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3 who completed cause of death (Item 23a) (Type, Print) N 0 419 W. Redwood St. Baltimore MD 21201 KENMED 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

State of Maryland / Department of Health and Mental Hygiene 2004 05398 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ERIC AMAZAN 9:50 A M JEAN February 13,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Sring Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 24,1942 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1⊠M 2□F Days Hours Country) Haiti 61 212-02-1745 Director Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10a State 10d. Inside City Limits 1X Yes 2 No Director Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ USA Ітаттв 23а 20814 5721 Grovegr Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ 1 Tes 2 No Specify: Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced "natural" al Hygiene. I other than "natura vent, the Moulcal E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Private permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: If Item 27 ia marked onto any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elda Etienne Delane Amazan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 712 Emerson Street, NW, Washington, DC 20011 19a. Informant's Name/Relationship (Type, Print) Jean E. Amazan - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb.21,2004 Mt. Olivet Cemetery Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home Georgia Ave., NW, Washington, DC 20011 nh Maris 27a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition 1 Sahon **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** erebro Vasculer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Lugulin law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the buria Penfension Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disorder 2. No 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes Be Completed severalized 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? (es 2 X No 1 🗌 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending To the moorest death.

To the Funeral Director: After the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in by the funeral bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in bird in b 2 No investigation 1 | Yes 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6520 Democromy 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records,

MARON, JEAN

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- Hegistrar	State of Maryland / Der FH,G828,2/20/2004,	Certificate of Death	Re	g. No.	05399
1. Decedent's Name (First, Middle, Las	1)	۸ (:	2. Date of Death		3. Time of Death
/Medical MINIEW		<i>1</i> (1)	Februar	15 2004	0244 AM
Examiner 4a. Fecility Name (If not institution, give		4b. City, Town, or Location of I	Death	4c. County of Death	
Johns Hopkins H  5. Social Security Number 6. So	7. Age (In yrs. last birth	Baltimore nday) If Under 1 Year   If Under 24		9. Birthpl	ece (State or Foreign
Director N/A	<b>X</b> M 2□F Y	rs. O2 O7 Hours	12 07	O3 County	(y)
Usuel Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		110	d. Inside City Limits
MD Howa		-		]"	1 □ Yes 2/□X90
The Married Status  10a. State 10b. County  MD Howa  10a. Street and Number  7289 Oakland M  11. Marital Status		10f. Zip Code	10	g. Citizen of What Count	ry?
7289 Oakland M	ills Road	21046		U.S.A.	
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No- luerto Rican, etc.)	14. Race - America Black, White, e	
10a. State 10b. County  MD Howa  10a. Street and Number  7289 Oakland M  11. Marital Status  12. Milever Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grants)  15. Decedent's Ed (Specify only highest grants)  Elementary/Secondary (0-12)	1 ☐ Yes 2 █️No If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No Specify:		Spacific	ack
3   Widowed 4   Divorced	ucation 16a. I	Decedent's Usual Occupation	1	6b. Kind of Business/Ind	
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N A Elementary/Secondary (0-12) N/A 17. Father's Name (First, Middle, Last)	N/A	N/A		N/A	
<u> </u>	- w		Name (First, Middle, M.	•	
LIGE DOT DITE HOUN		Mailing Address (Street and Number of	n Muhamme		Codel
≥ ซูฐ์ฉู๊ะ   Mursal Ali Abu	kar <del>-Dather</del> 728	39 Oakland Mill			
20a. Method of Disposition	comoton	Disposition (Name of crematory or other place)	Date 20	Oc. Location - City or Tov	m, State
XXBurial 2 □ Cremation 3 □  **A □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licen	King N	Memorial Park 2	/16/04 R	andallsto	wn, Md
Build 2 Cremation 3 C	See // ()	22. Name and Address of Facility March F/H West	723		8701490
23 Pert 1. Ever the disease, or comp	linations the caused the death. Do no	4300 Wabash Av			1215 Approximate
shock, or near trailore. List only o	one cause on each line.	of the fire mode of dying, such as ca			Interval Between Onset and Death
Physician disease or condition resulting in death)	a. HCUTE 1650	ilatory usines	s sino	(rome	Im
Examiner	Respiratory S	suncital Viva	& Prou	morua	122
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	): )			
fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	<b>3.</b>			
cause. Enter (Indentying Cause) (Disease or injury that initiated events resulting in death) Last		).			
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Physician (1992)  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  9   Unknown  9   Unknown  9   Unknown  9   Unknown  9   Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 ☐Ectopic pregnancy		23d. Date of deliver	,
• O O O I I I I Tes 2 I NO	4 Pregnant at time of death	5 Other (specify)		Month E	ay Year
		the underhise seven such is Rost !	23a Didaaha		
Spend Skeletal Dus	DULTA	ine driderlying cause given in Fatti.		cco use contribute to the	oly 4 Unknown
Skeletal Dys  Skeletal Dys  Thalamic  Sepsis	emper hage		24a. Was an		sy findings available
P 0 = 2 E	Triorriage		<ul> <li>autopsy performe</li> </ul>	prior to com death?	oletion of cause of
E e e e e e e e e e e e e e e e e e e e		26. Place of	1 ☐ Yes 2 ☐ Death (Check only one)	Mo 1 ☐ Yes 2	
Yes 2UNO	Hospital: 1 ☑Inpatient 2 ☐ ER/Outp		g Home 5 Residen	ce 6 □Other (Specify)	
27. Man or of Death  28. Man or of Death  Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Tir	ury Work?	28d. Describe how	injury occurred	
T ⊆ F G 1 Matural 5 Pending		M 1 Yes 2 No		et and Number or Bural	
1 Matural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, fam	street factory office	28f Location (Stre		Poute Number
To continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo del continuo de la continuo de la continuo del continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo de la continuo del continuo de la continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del continuo del con	28e. Place of Injury - At home, fam building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,	State)	Route Number,
Solicide to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr	building, etc. (Specify)  sician: To the best of my knowledge.	death occurred at the time, date and n	City or Town,	se(s) and manner as etc	ad
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State of Maryland / Department of Health and Mental Hygiene 2004 05400 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** Victoria Aviq February 19,04 12:47p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Future Care Canton Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4-15-1926 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** Days Hours 1 □ M 287 F 77 Director 213-26-0088 Baltimore, MD Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1XYes 2 No Baltimore Director n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 404 S. Exeter Street USA Completed by Funeral filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I □ Yes 2 12No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☒ No Specify 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. In own home Homemaker 8th other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 9 Antonia Gazzuola Luigi Guarino 19a. Informant's Name/Relationship (Type, Print) brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 ie.
any injury or other traus 708 Slew Ave. Lawrenceville, GA 30043 Joseph Guarino 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Most Holy Redeemer 2/23/04 Baltimore, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr.FH annuo 263 S. Conkling St., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death bre brova scular accident Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) interischer **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death signed by the at d be detached for 5 Other (specify) 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 : has certificate 1 Yes 2 2 No or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Beath (Check only one) Hospital: ↑ ☐ Inpatient Other: 4 Warsing Home 5 Residence 6 Other (Specify) 2 **N**O 1 🗌 Yes Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 5 Pending 1 Natural Injury after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Direct Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) W11150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TORRES, MO 441 S. ELLWOOD AUE BACTO, MD 21224 MELITOM. 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State FEB 2 0 2004 Registrar

THANIEL		State of Maryland / Department of Health and Mental Hygiene 2004  Certificate of Death Reg. No.	051.01
	1 - State Registra	Certificate of Death Reg. No. 2004	03401

		- State Registrar			Cert	ificate of l	Death		Reg. No.	2004	03401
		1. Decedent's Name (First, Middle, Last)						2. Date of De	aath Day	Year	3. Time of Death
Physic /Med		Nathaniel		В	rown			FEB.		2004	11:58 A <sup>M</sup>
Exam		4a. Facility Name (If not institution, give s	treet and number)	******		4b. City, Town, or	Location of Deat	h	4c. (	County of Death	
		GOOD SAMARITAN HO	SPITAL			BALTIMO	RE CITY			NA	
Funera	!	5. Social Security Number 6. Sex	M 000	In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth ay, Year)	9. Births	place (State or Foreign
Directo	r	214-00-1417	M 2□F 47	7	Yrs.			8-25-5		Mc	
and *		Usuel Residence of Decedent  10a. State 10b. County	1	IOc. City, To	wn or Loc	ation					Od. Inside City Limits
Aaryla eho	ō				ltimo						1√2 Yes 2 No
the A	Director	Md. NA 10e. Street and Number		Da	TLTHI	10f. Zip Code			10a Citiz	zen of What Cour	
with with		1220 E. Coldsprin	ng Lane			21239	9			USA	,
Jeath Tie 23	Funeral		2. Was Decedent Ev	er in U.S.	13. W	as Decedent of Hi Yes, specify Cuba		Specify Yes or No		14. Race - Americ	
atter o	Fur	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No If Yes, Give					to Rican, etc.)		Black, White,	
ING 21213-UU36 be filed within 72 hours after death with the Maryland ital Hygiene. d other than "netural", or iteme 23a or 28e-f show event, the Medical Examination misting and	by	3 Widowed 4 Divorced	Year or Dates:		1	☐ Yes 2 No	Specify:			Specify: Blac	:k
2-C	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16	(Give k	ent's Usual Occupa	durina most of wo	rking	16b. Kin	nd of Business/In	dustry
Marin Marin	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)			O NOT use retired	)		Mata	1	Maintanana
filed w Hygier other th		11th grade 17. Father's Name (First, Middle, Last)			Main	tenance	18. Mother's Na	ma /Cinat Adiatella		-	Maintenand
S da B S	Be	Nathaniel	Bro	own, S	r			izabetn	, Maidell S	Lew	ris.
Maryia d 2 should th and Men 7 ie marke traumatic	2	19a. Informant's Name/Relationship (Typ				Address (Street a			or City or		
Mar nd 2 sho lith and 27 ie m		Elizabeth Jones	Sister		_	ello Ct.				205	0000)
or Health	-	20a. Method of Disposition	DIBCCI	20b. Place	of Disposi	tion (Name of		Date		cation - City or To	own, State
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Ealtimore, permit. Pages 1 at Department of Hea important: if item any injury or othe		21. Signature of Funeral Service License	0 / //	<del></del>	22.	Name and Addres	s of Facility	Baltin	ore,	Md. 21	202
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1		30. Name and address of person who co	P leted cause of dea	th (Item 23a)	(Type, P	rint)					
/		5. R. 1-609 A				Street,	Baltim	ore, Mar	yland	1 21201	
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	1	a					
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18 Z	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Wa				gin? (Spe	ecify Yes or No- Rican, etc.)		4. Race - Ame	rican Indian,	
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or of		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐	Removal from State	cemet	ery, crema	tory or o	ther place							
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filled	O	29a. Certifier 12 Certifying Ph	ysician: To the best o	f my knowled	ge, death	occurred	at the time	e, date ar	id place.	and due to the	cause(s)	and manner as	stated.	
Fun tely	edical	(Check only 2 Medical Exam	niner: On the basis of and manner sta	examination a	and/or inve	estigation	, in my op	inion, dea	th occur	red at the time,	date and	place, and due	to the cause	(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] 05403 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** February 15, 2004 12:55 PM Elizabeth Margaret Bowen /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 298 Wakely Terrace Bel Air Harford 8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Country)
Nov. 28, 1916Washington, DC 5. Social Security Number 7 Age (In vrs. last hirthday) Birthplece (State or Foreign Country) **Funeral** 1□M 25 F 213-38-5133 87 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other then "netural", or Itams 23a or 28a-f show ury or other traumatic event, the Medical Exactinat ment by publical at 1 ☐ Yes 2 X No Completed by Funeral Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 298 Wakely Terrace 21014 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care 8 Practical Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benjamin Elkins Maddox Carrie Elizabeth Marion ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3245 History Drive Oakton, Virginia 22124

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town Patricia Bowen / Daughter 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2∑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If ony injury or Hilltop Service Corp. 2-17-04 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition avion Physician resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Completed by Physician/Medical as the l IF FEMALE 950 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy should be detached for Year Month Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 No 0 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 1 Yes 2 No Division of Vital To the Hospital or Attanding Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of centrier 29c. License number 29d. Date signed (Month, Day, Year) 00038972 of person who completed cause of death (Item 23a) (Type Print)

State Registrar 31. Date filed (Mort)

32. Biggistrar's Signature

Belvedere fre Bilto M V 21415

State of Maryland / Department of Health and Mental Hygiene 2004 05404 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 7:18 **Physician** Februa! 18 2000 Gladys Cecelia Brown /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Agnes Hospital Baltimore If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 78 219-18-4361 Oct 4, 1925 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hyglene.
nent of Health and Mental Hyglene.
nent if item 27 is marked other than "naturel", or items 23e or 28e f show must if item 27 is marked other than "naturel", and item must be rediffied at my or other traumatic event, the Medical Examinar must be rediffied at 10a. State 10b. County 1 Yes 2 No Maryland Director Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7907 Aylesford Lane 20707 United States Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Completed by 3√2 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lyman Cato Howe Mary Ellen McHugh 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie C. Kilgallon / Daughter 7907 Aylesford Lane, Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or oti
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Bunal 2 □ Cremation 3 □ Removal from State Meadowridge Mem. Park 2/21/04 Elkridge, Maryland \* 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenspe 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemorrhagic
Due to (or as a consequence of): **Physician** one day disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner sician and burial-transit Due to (or as a consequence of): Box 68 60. Physician/Medical attending phy IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 24a. Was an has autopsy certificate 1 ☐ Yes 2 No of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and tale of certifier 29c. License number 29d. Date signed (Month, Day, Year) House shakhoods, MD elficel P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Baltimore MD H. Parakhoode Caton Ave. 31. Date filed (Month, Day, Year) FEB 2 0 32 Registrar's Signature State 2004 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

511	ER DROW	IN	1 - For State Registrar		ryland / Depa <i>Cei</i>	artment of F	Death		neg. No.	004	05405
	Physici	an	Decedent's Name (First, Middle, Last		. 131 1	D		2. Date of De	Day	Year	3. Time of Death
	/Medic	al	A. Falls Many Many Control	Lester	Floyd	Brown	- Landing of David	FEB.	10, 20		12:21 P M
*	Examin	er	4a. Facility Name (If not institution, give JOHINS HOPKINS HOS				ORE CITY			y of Death	
7	Funeral Director			x 7. Age	(In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 8-5	rth ay, Year) -1947	9. Birthp Cour	place (State or Foreign ntry) Va
	how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
	Ba-f s	Director	Md N/A		Baltime	ore					1 AYes 2 No
	with the		10e. Street and Number 2911 Edgecomb Ci	rcle South	1	10f. Zip Code 2121	15		10g. Citizen of		ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Exercites most be notified at ances.	by Funeral	11. Marital Status  12 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 24 No If Yes, Give Year or Dates:	1	Was Decedent of his types and the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are the second of his types are	Hispanic Origin? (S) an, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	14. Ra Bla Specii	ce - Americ ick, White, fy: B1	
15-0	n 72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	dent's Usual Occup kind of work done	oation during most of world)	king	16b. Kind of E	Business/In	dustry
21215-0036	d withir giene. er than	omp	Elementary/Secondary (0·12) 12th grade	College (1-4or 5+	)	ekeeping			G. 1	в. м.	С.
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It's Ma	Be	17. Father's Name (First, Middle, Last)	Unk			18. Mother's Nam	ne <i>(First, Middl</i> e ery Bro		me)	
3	should Ind Men	은	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailir	ng Address (Street	and Number or Ru			. State. Zio	(Code)
	1 and 2 s Health ar Iam 27 is other trau		Margery Wilkens			,	d Circle		Balto, 1		,
Baltimore,	of Head of Head If itam		20a. Method of Disposition  1 🖾 Burial 2 □ Cremation 3 □ F	Removal from State	20b. Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location		
Ĭ	tment tant: I		* 4 □ Donation 5 □ Other (Specify)	1	Garrison			-2004	Owings	Mill:	s, Md
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other QDCB.		21. Signature   Funeral Service Licens	5	22	. Name and Addre	M	arch F/I Wabash	H West Avenue	Ba1	21215 to, Md
2	Physician /Medical Examiner		23a. Part 1. Enter the disease or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a Stab woun	).		t logarl m			ids	Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the buriat-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	с	consequence of):						
.O. Box 68	death certif e attending od for use as	Physician/Med!	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐Fetal death 3☐	Ectopic pregnancy	/			ate of delive	ery Day Year
S,	w requires that the s been signed by th should be detache	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the ur	nderlying cause giv	ren in Part I.	23e. Did t	A. comment		ne cause of death?
Vital Record	e la has	Completed						24a. Was auto perfo 1 X Yes	psy prmed?	Were auto prior to cor death?	psy findings available impletion of cause of
Ita	ysician: Th	Be C	25. Was case referred to medical examiner?				26. Place of Dea				
ot <	d is	္	1 XYes 2 □ No	Hospital: 1  Inpatient			4 Li Nursing H		dence 6 Oth		1)
	ling After fune	atlon:	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day)	Year) Injury	28c, Injur Wor A M 1 □	y at k? Yes 2 ⊠No	Deceus	now injury occur ed stabl	red o	relant
Division	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☑ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office Nome	,	City or To	Street and Numl wn, State) 12 (	per or Rura	Poure Number,
	e Hospi 24 hou e Funer etely fill	edical		sician: To the best of iner: On the basis of e and manner state	examination and/or inv						
	To the within To the	Me	29b. Signature and title of certifier	$\sim \sim$	\	29c. Licens	e number		29d. Date signe		Day, Year) 2004
•	17X,		30. Name and address of person who co	ompleted cause of dea	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s			65.55	1974		
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State of Maryland / Department of Health and Mental Hygiene 05406 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Hilda Evelyn Berger 30 a M 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Boseda If Under 1 Year Franklin Square Center HOSPI ta If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 □ M 2 1 Hours 169-18-5395 82 Pennsylvania Director Usual Residence of Decedent 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avent, the Medical Examinar must be notified at Maryland Baltimore Middle River 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 19 Chandelle Road U.S.A. Items 23e 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes **2/**T√No f Yes, Give 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ Specify 3€Widowed 4 □ Divorced Year or Dates: White "natural". 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Elmer Schwab Flossie Fransburger 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health item 27 i Colleen McGowen (Daughter) 2741 Calkins Road, Oak Hill, Virginia 20171 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 

Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gard 2/21/2004 Baltimore, Maryland <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility,
Bruzdzinski Funeral Home, P.A. 21. Signature of Edneral Service Licensia 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, surek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm state Cause (Final **Physician** disease or condition resulting in death) ar Doronary /Medical Due to (or as a consuluence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Critical acr Due to (or as a consequence of) Examiner burial-transit the death certificate be executed and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 5 Other (specify) 4☐Pregnant at time of death ed by the a □Yes 2□No P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 2 X No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 1 ☐ Yes 2 No 1 Inpatient 3□ DOA Sins 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 🗌 No death. 1 Tes 2 Accident after death Director: in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō within 24 hours a To the Funeral L Hospital pellil VECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 61104 ð 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1000 frant 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB2 0 2004 Registrar

			- State Amended Item#2	State of Maryl 3a,b,25,27,28a	and / Dep f,Per Æ	artment o	of Hea	lth and ath			004	05407
	Physici	an	1. Decedent's Name (First, Middle, Las Lillian A. Bou	ichat					2. Date of De Januar		2004	3. Time of Death 12:30P M
	/Medio Examin		4e. Fecility Name (If not institution, give			4b. City, To	_	ation of De	ath		unty of Death	
	Funeral Director		5. Social Security Number 6. St 217–34–3659	9X 7. Age (In )	yrs. last birthday, 85 Yrs.	If Under 1 Months E		Jnder 24 H ours Mi		<sup>th</sup> 2 <sup>Year</sup> 19	9. Birthp 18 Mar	lace (State or Foreign ty) Land
	show		Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimo		. City, Town or L				<u> </u>		1	0d. Inside City Limits
	with the M a or 28a-f Le notifi	Director	10e. Street and Number 2222 Sulphur Spri	ing Rd.		10f. Zip Co 212				10g. Citizen	of What Coun	itry?
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23e or 28e-f show event, the Middical Exercitival cast for cridified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates:	in U.S. 13.	Was Deceder If Yes, specify 1 ☐ Yes 2 ☑		nic Origin? lexican, Pui pecity:	(Specify Yes or No erto Rican, etc.)	:	Race - Americ Black, White, ecity: Whi	etc.
Maryland 21215-0036	within 72 hou ene. than "nature he Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	edent's Usual ( e kind of work of DO NOT use	done durin retired)	g most of w	vorking		of Business/Ind	
and 21		To Be Col	6 17. Father's Name (First, Middle, Last) Paul H. Forema		HO	memake1	18.		ame (First, Middle	Maiden Su	wn Home mame)	
	d 2 shouth and h	ř	19a. Informant's Name/Relationship (			,	Street and I	Number or	Rural Route Numb	er, City or To		Code) MD. 21227
Baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition 1	Removal from State	Db. Place of Disp cometery, cre Slen Hav	osition (Name ematory or othe en Memo	of er place) orial	Park	Date 01-15-03	20c. Locat	ion - City or To n Burni	e, MD.
Balti	permit. Pages Department of t Important: If its any injury or o once.		21. Signature of Funeral Service Licer  23a. Part1. Enter the disease, or com	PRG		2719 F	se Fui Hammoi	neral nds E	Home of erry Rd.	Lanso		MD 21227 Approximate Interval Between
8760,	Physician /Medical Examiner per percentage with physician and physician and physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physician physican physician physician physician physician physician physician p	ilcal Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Esqueritally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a cor	sive Sections Insequence of):	re	CAL	0.00	ASEULA.	Disc	ense	Onset and Death 4 DAYS 4 EARS
P.O. Box 68	Physician: The law requires that the death certificate tribs certificate bas been signed by the attending physic rail director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pr 1  Live birth 2 4  Pregnant at time 9  Unknown	Fetal death 3	□Ectopic preg	nancy	***			. Date of delive Month	ery Day Year
	w requires that the deben signed by the should be detached		Part II. Other significant conditions of	_	,	underlying cau	ise given ir	Part I.				ne cause of death?
Reco	sician: The law rec certificate has bee irector, page 2 shot	Completed by	SUBDURAL	HEMATO.	71				24a. Was auto perfo 1 \( \text{Yes}	psy prmed?	4b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	psy findings available mpletion of cause of 2 No
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Division of Vital Records,	Ilng After	tlon: To	1 X Yes 2 1 No.  27. Manner of Death 1 1 No. 2	28a. Date of Injury (Month, Day Ye		of 280	c. Injury at Work?	4 □ Nursing	Home 5 Res 28d. Describe	how injury o		y)
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined		At home, farm, s pecify)	treet, factory,	office		28f. Location (	Street and N wn. State) NUL Spr	ing Rd.,	I Route Number, Janscowine, MD
	Hospi 24 hour Funer etely fill	Medical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of my miner: On the basis of exa and manner stated.	y knowledge, dea mination and/or	ath occurred at investigation, in	the time, on my opinion	date and pla on, death or	ace, and due to the ccurred at the time,	cause(s) an date and pla	d manner as s ace, and due to	tated. the cause(s)
•	To the Within To the comple	Me	29b. Signature and title of certifier	Cut	LAD		License nu		44		igned (Month,	-
		1000	30. Name and address of person who			e, Print)	TRE	OCE	ere RO	2122	9	
	Si Regis	ate trar	31. Date filed (Month, Day, Year) FEB 2 0	32. Registrar's	Signature	End's			7. F. France		4	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** February 18, 2004 5:55 p M Rodolfo William Britto /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Prince George's Laurel Regional Hospital Laurel tf Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year Oct. 3, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** Months 1√2 M 2□ F 93 Gibraltar 050-01-3114 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10h County 10a, State Items 23a or 28a-f show ust be nutified at 1√√Yes 2 No Maryland Prince George's Laurel Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20707 7700 Cherry Lane U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritat Status the Medical Examiner of Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 06 1 Yes 2XXVo Baltimore, Maryland 21215-0036 Specify. Specify: White þ 3XWidowed 4 □ Divorced natural', Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Grade 10 Finisher Garment other 1 other traumatic svent, 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health, and Mental Hy Important: If Item 27 is marked ofth any injury or other traumatic avent, socie. 17. Father's Name (First, Middle, Last) Be Frank Britto Florentina Oates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Wagner daughter 677 Old Waugh Chapel Road Odenton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Church Cem Feb 23, 04 Laurel, Maryland 21. Signature of Funeral Service Licensee Bonaldsones Fundival Home, P.A. 5 67 / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** Pneumonia 1 week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 No o 9 Unknown signed by مَ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records. Alzheimer's 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 ☐ Yes 1 🗌 Yes Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Mapatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XXNo Certification: To 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 5 Pending investigation XXNatural 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral C 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical mpletely (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Muchand D0036716 February 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kundrat, M.D. 8317 Cherry Lane Laurel, Maryland 20707 31. Date filed (Month, Day, Year) FEB 2 32. Registar's Signature State Registrar

			1 - For State Registrar	State o	of Maryland	d / Depa <i>Cei</i>	artment of tificate of	Health a	nd Mental H	łygiene Reg. No.	2004	05409
		П	Decedent's Name (First, Middle,	Last)					2. Date of	Death		3. Time of Death
ı	Physici /Medic		Carolyn M	ay Bl	ankenshi	D			Febru	Day arv 18	9 Year 8, 2004	8:00 p M
?	Examir		4a. Facility Name (If not institution,				4b. City, Town,	or Location of			County of Death	О.ОО Р
			14 S. Lightner S	treet			Uni	on Brid	ige		Carroll	
	Funeral Director		5. Social Security Number 213-46-6790	3. Sex 1 ☐ M 2 <b>X</b> ☐ F	7. Age (In yrs. In 59	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2	4 Hrs. 8 Date of	Birth Day, Year)	9. Birthr Coul Mary	place (State or Foreign atry) and
	P .		Usual Residence of Decedent		10-00							
	anyla shov	-	10a. State 10b. County	1.7		r, Town or Lo					1	0d. Inside City Limits
	Ne M	Director	Maryland Carro	<u> </u>	Uni	on Br						1 ☐ Yes 2 ☐ No
	with the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of the page of t	늄	10e. Street and Number 14 S. Lightner S	treet			10f. Zip Code 21791			1	izen of What Cour S • A •	ntry?
	leath ne 23	era	11. Marital Status		edent Ever in U.S	S. 13 V		Hispanic Origi	n? (Specify Yes or		14. Race - Americ	ean Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "naturel", or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	orces? 2 <b>∐X</b> No ve		Yes, specify Cut		n? (Specify Yes or Puerto Rican, etc.)		Black, White, Specify: Wh:	etc.
21215-0036	2 hou		15. Decedent's	Education		16a. Deced	lent's Usual Occu	pation		16b. Ki	nd of Business/Inc	dustry
215	hin 7.	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (	1-4or 5+)	(Give life. L	kind of work done OO NOT use retire	during most o	of working			,
	d wit	ПОС	Grade 12	ooogo (		Homer	naker			(	Own Home	
Maryland	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, La	ist)				18. Mother	s Name (First, Mid	dle, Maiden	Sumame)	
yla	Meni Meni arke	ပ	Caleb Wilson					Iva E	Bell			
Jar	2 sh and Ism raum		19a. Informant's Name/Relationshi						or Rural Route Nu			
	1 and 1ealth 1m 27 ther t		Iva Knight / d 20a. Method of Disposition	aughter 	20h Pi	-	LIGNTN sition (Name of	er Stre	et Unio	-		21791
Baltimore,	Pages ment of t ant: If it ury or of		1 ☑ Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Contr		State C6	metery, cren	natory or other pla	· 1	eb. 20, 0		cation - City or To	
Balt	Depart Import eny inj		21. Signature of Funeral Service Li	censee	/ M0077				al Home, nue Laur		rvland	20707
			23a. Part1. Enter the disease or co shock, or heart failure. List or	omplications that only one cause on e	aused the death.	. Do not ente	or the mode of dy	ng, such as ca			ily Iunu	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition		MEL	_AN	OMA	4				Onset and Death
	/Medical		resulting in death)	Due to	(or as a consequ	ence of):						14
ı	Examiner		Sequentially list conditions.	b								/
7	D ii	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interested early).	Due to	(or as a consequ	ence of).						
	and I-tran	Examin	that initiated events resulting in death) Last	c	(or as a conseque	anna of):						
8760,	icate be executed physician and s the burial-transit	alE			(or as a consequ	61106 OI).					1	
387	icate phys	dlcal		d								
Box (	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as	Physician/Me	tF FEMALE: 23b. Was decedent pregrant in the past 12 morths?	1□Live b	come of pregnan	death 3 🗌	Ectopic pregnanc	у		2	3d. Date of delive	ry Day Year
o.	that the de led by the a detached f	yslc	1 Yes 2 No 9 Unknown	9☐ Unkn	ant at time of dea	atn 5⊔	Other (specify) _			-		24,
۵.	res that igned b	by Ph	Part II. Other significant condition	contributing to de	eath but not resul	iting in the un	derlying cause giv	ven in Part I.	23e. Di	d tobacco us	se contribute to th	e cause of death?
Records,	w require been sig should b	ed b							1[	]Yes 2∭t	3 □ Prob	abiy 4 Dunknown
၀ ဂ	law re	Completed							24a. W		24b. Were autop	sy findings available
~	The lav	EO							— au pe 1  Yes	topsy rformed? 2 12 No	death?	ipletion of cause of
Vital	ysician: This contilicate	Bec	25. Was case referred to medical examiner?					26. Place of	Death (Check onl		10163	2(3)110
<u>~</u>	g	10	1 ☐ Yes 2 ☑ No	Hospital: 1 □ I	npatient 2 🗆 🗧	R/Outpatient	3□ DOA Ott	ner: 4 🗆 Nursi	ng Home 5 TA	sidence 6	☐Other (Specify	)
Division of	ding Ph J. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury	28c. Inju		28d. Describ	e how injury	occurred	
<u>s</u>	Attending r death. ector: After by the fune	cat	2 Accident investigat 3 Suicide 6 Could no	he	of labour At hear	4		Yes 2 □ No				
Ω	tel or Attences after death	Certification;	4  Homicide determine	ed 289. Flace buildi	of Injury - At honing, etc. (Specify)	ne, rarm, stre	et, factory, office			(Street and own, State)	l Number or Rural	Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	aminer: On the ba	best of my know asis of examinationer stated.	rledge, death on and/or inv	occurred at the tile estigation, in my o	me, date and p ppinion, death	place, and due to the concourred at the time	e cause(s) a	and manner as sta place, and due to	ited. the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier	/ A-			29c. Licens	se number		29d. Date	signed (Month, E	Pay, Year)
	~/	*	* Kallun A	111/8	MD		103	539,	X	2-	19-	4
	8		30 Name an address of person with	o completed caus	e of death (Item :	23a) (Type, F	Print)	37	WESTA	INSTR	ER MA	21157
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2		egin rar's Signatu	ire /	breet is					•
			FLUN	O FOOLS	THE WALLS	10						

			For State Registrar	State of Ma	aryland	/ Depa	artment of F	lealth and	Mental Hyg	giene 20 (	0541
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, La Curtis Verle B.     Aa. Fecility Name (If not institution, gin	arnes	` 1 1		4b. City, Town, o	r Location of Deat	2. Date of Dea Month Februar	Day Yea	4 8:50 M
	Funeral Director			TE HOSPI	e (In yrs. las	st birthday) 31 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth		MOTE Birthplace (State or Foreign Country)
	after death with the Maryland or Iteme 23e or 28e-f show miner must be notified at	ector	Usual Residence of Decedent  10a. State 10b. County  MD Baltin	more		Town or Lo Roseda	le				10d. Inside City Limits 1 ☐ Yes 🏋 No
	ath with t	ral Dir	8008 Neighnors	Avenue			10f. Zip Code 21237		1	0g. Citizen of What USA	Country?
5-0036	tiled within 72 hours after death with the Maryland Hygiene. Hygiene, then "natural", or Iteme 23e or 28e-f ehow ent, the Marical Examiner must be notified at	d by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 12 Yes 2 1 If Yes, Give Ty Year or Dates!			Vas Decedent of H f Yes, specify Cubi ☐ Yes 2🔯 No	lispanic Origin? (S an, Mexican, Puerl Specity:	pecify Yes or No- to Rican, etc.)	14. Race - Ar Black, W Specify: [w	-
215-	d within 72 h jiene. ir then "natu	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5		(Give life. L	lent's Usual Occup kind of work done OO NOT use retired	ation during most of wo	rking	16b. Kind of Busine	,
Cortand 21	ed la b	To Be Col	12 17. Father's Name (First, Middle, Lasi Arban C. Barnes			Sup	ervisor		Ne (First, Middle, 1 Blaney		ectric Co.
` ≥	nd 27 I		19a. Informant's Name/Relationship Virginia Mae Ba		2	19b. Mailin 8008	g Address <i>(Street</i> Neighbor	and Number or Ru S <b>Avenue</b>	ral Route Number Rosedale	City or Town, State	, Zip Code) 237
Arnes Baltimore.	S		20a. Method of Disposition  1XX Burial 2 Cremation 3 (  14 Donation 5 Other (Speci		cen	ce of Dispos netery, cren ney V	sition (Name of natory or other place alley			20c. Location - City	
Baltimor	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Lice			22	Name and Addre	no of Capility	-	lale FUner	
0	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Acu	te 1	Do not ente		g, such as cardia		est,	Approximate Interval Between Onset and Death
8760,	Examiner transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as  c. Due to (or as  d.	a conseque	nce of):	rtery '	Disea	se	8	
.O. Box 68	eath cer attendin for use	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	eath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
rds, P	w requires that been signed b	by	Part II. Other significant conditions Diabetes	contributing to death b	ut not resulti	ing in the un	derlying cause giv	en in Part I.	23e. Did tob	3.7	to the cause of death?  Probably 4 □Unknown
Of Vital Records, P.O.	i: The law re icate has been, page 2 sho	Completed		Sion					24a. Was as autops perform	y prior to ned? death	autopsy findings available completion of cause of ? es 2 \(\sum \) No
of Vit	hysician this certif	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital: 1  Inpatie		R/Outpatient		er: 4 🗌 Nursing H	th <i>(Check only on</i> ome 5 ☐ Reside	e) ince 6 □Other (Sp	pecify)
Mivision o	ending Paath. or: After I	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		ry y Year) 2	8b. Time of Injury	28c. Injun Worl	/ at k? Yes 2 □ No	28d. Describe ho	w injury occurred	
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certifle	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At hom c. <i>(Specify)</i>	e, farm, stre	et, factory, office		28f. Location (Sti City or Town	reet and Number or i , State)	Rural Route Number,
	he Hosp in 24 hou he Funei pletely fil	edical	29a. Certifier 1 ✓ Certifying PI (Check only one) 2 ☐ Medical Example (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner ate and place, and di	as stated. ue to the cause(s)
	2 × × ×	W	29b. Signature and title of certifier	mi s	Ah	مجرة	29c. License		25	Date signed (Mon	nth, Day, Year)
	17		30. Name and address of person who	Ja . 9001	eath (Item 2	(3a) (Type, F	N Savas	e Drive	Balti	ebruary more, m	D 21237
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	a de	borks				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05411Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death PEBPUARY **Physician** 18 2004 11-20 Pm William E. Buck /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner NOBAL ARUNDEL HOSPITAL ANNE ARUNDEI TEN BURNIE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06/05/1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Director 213-32-5845 MD Usual Residence of Deceden Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 216 Cloverhill Road 21122 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 Mayes 2 □ No 1955 — If Yes, Give Year or Dates: 1957 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 5 1 ☐ Yes 2 No Specify Be Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 1957 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Ma once. Elementary/Secondary (0-12) College (1-4or 5+) Sr. Mechanical Tech Spc 12 Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Ottis Buck ပ Frances Erbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 Cloverhill Rd., Pasadena, MD 21122 Catherine Buck/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 2/21/4 Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee G.J.Gonce Funeral Home, PA 169 Riviera Dr., Pasadena, MD 21122 23a. Part1. Enter the dislase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner ALLIPE ettending physician end for use es the bunel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last OTATH Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1\_ Yes 2 No 1 ☐ Yes 2 1 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Medical Certification: To Hospital: Other: 1 Yes 2 No 2 ☐ ER/Outpatient 3□ DOA nours efter death.

neral Director: After this y filled in by the funeral di 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide in 24 hours
of the Funeral Discompletely filler Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier \$ 29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and eddress of person who con leter cause of death (Item 23e) (Type, Print) Busme Hospital Drive DNABA

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

0 2004

Baltimore, Maryland 21215-002

Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05412 Certificate of Death 2. Dete of Deeth Month Dey Year 3. Time of Death

				Certificate of Death	Reg. No.	03412
	<b>S</b> : :		1. Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month Dey Year	3. Time of Death
	Physic /Medi		Mattie Boston		February 16 2004	1 0850A
	Exami		4a Facility Neme (If not institution, give street and number)	4b. City, Town, or	Location of Death 4c. County of Dee	
			Stella Maris at Merci	y Balti	more NI	A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	Months Days Hours Min.	8. Date of Birth 9. Birth (Month, Pay, Year)	hplace (State or Foreign
	Director	Ž.	214-38-7859 10M 2PLF 68	Yrs.	Nov. 6, 1935 No	rth Carolin
	pu .		Usuel Residence of Decedent  10e. State 10b. County 10c. City. 7	own or Location		10d. Inside City Limits
	show a show	'n	MA / / A//A	, 1.		1 1 Yes 2 □ No
	the M	ecto	Maryland N/A	altimore		, -
	th with the Maryle 23a or 28a-f sho	Funeral Director	10e. Styleet end Number	10f. Zip Code	10g. Citizen of What Co	ountry?
	ath w	rai	3025 Normount Ct.	2/2/6	USH	
	ter des	Š	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li> </ol>	Specify Yes or No- to Rican, etc.) 14. Race - Ame Black, Whit	
20	s aff	by F	1 ☐ Yes 2 A No 1 ☐ Yes 2 A No 14 Yes, Give 2 ☐ Yes or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify:	16
Ş	72 hour natural	8		So Bootselle Head Convention	5	lack
5		To Be Completed	(Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of world, DO NOT use retired)	rking 16b. Kind of Business	industry
12	withir ene. than	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)	1 1 2 2 5 2 3 3	1000	Aru
9	be filed with ital Hygiene. d other than event, the N	ŏ	17. Father's Neme (First, Middle, Lest)	Laborer 18. Mother's Nar	me (First, Middle, Maiden Sumame)	ary
an		B	Tack Lugas	Fran	as 0/1:0	,
2	should be filed and Mental Hygi marked other imatic event,	ř	19a. Informant's Name/Relationshic (Type, Print)	19b. Mailing Address (Street and Number or Ru	CES USB 12	Zin Code)
Maryland 21215-0020	2 0 0 0	1	Mrs Mac , Tuelington	2075	+ 0 + D 14	MA 5/5//
	ss 1 and of Health itsm 27 itsm 27 other tr		20a. Method of Disposition 20b. Plac	e of Disposition (Name of	Date 20c. Location - City or	Town State
Baltimore,	or or or		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	etery, crematory or other place)	2/20/2	11 610
ij	t. Pertrant		4 Donation 5 Other (Specify)	. Carmel	1/2004 Dunaa	IK, Ma.
Bal	pemit. Pege Depertment of important: If any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Funeral Home	
-	00200		Alleh L. Tuss	12222 W. North A	ive. Balto Md.	21216
			23a. Pert I. In er the discusse, or complications that caused by death. I shock or heart fail be. List only one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiretory arrest,	Approximale Interval Between
7	Physician		0			Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	nchosiic Con	Chroma	
1	Examiner		resulting in death)  Due to (or as	s a consequence o):	- rayou	
	sit 9d	Examiner	<b>a</b> b			
	be executed ician end buriel-transit	хап	Sequentially list conditions, if any leading to immediate	s a consequence of):		
68760,	oe ex	E	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury			
87	ohysi the t	dic		a consequence of):		
9 X	n certificete be execut inding physician end use as the buriel-trar	Physiclan/Medical				
Вох		lan				
	e de the a	/sic	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23b. Did tobecco use contribute	to the cause of death?
P.0	v requires thet the death been signed by the atta should be datached for	Æ			1 ☐ Yes 2 ☐ No 3 ☐ Po	obably 4 Unknown
	estt igne bed	Ď			-	
20	equi	g			performed?	Were autopsy findings available prior to
Ö	S S ¥					completion of cause of death?
<b>E</b>	o	Completed			111 Vis 2110	I □ Yes 2 □ No
Vital Records,		Be (	25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one)	
<b>&gt;</b>	S S D	2	Hospital'	Outpatient 3□ DOA Other: 4□ Nursing H	lome 5 ☐ Residence 6 ØOther (Spe	city) hospice
٥	ding Phys h. After this funeral d		27. Menner of Death 1 Naturel 5 Pending 28a. Date of Injury 28 (Month, Day Year) 28	b. Time of 28c. Injury at Work?	28d. Describe how injury occurred	
<u>Ö</u>	ath. r: Aff	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division of	Atta ar da ecto by th	130	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Street and Number or Ru City or Town, State)	ıral Route Number,
	To the Hospital or Attanding Ph within 24 hours aftar daath. To the Funeral Director: After th completely illied in by tha funeral	edical Certification:	ounding, etc. (opecity)		ony or rown, ordio/	
	ospit hour uners	cai	29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch	dge, death occurred at the time, date and place	, and due to the ceuse(s) and manner as	stated.
	in 24 the Fi		one) end mannor stated.		med at the time, date and place, and due	to the cause(s)
	Tot Tot Com	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Monta	n, Dey, Year)
			· ////	10 1937	2/11/104	
			30. Name end address of person who completed cause of deeth (Item 23	e) (Type, Print)	300	
			MERCY MEDICAL CENTER DR	MARUIN J. FELDM	nan. mo 2120	2
		1				

DHMH 16 Rev 6/95

Registrar

Boston, MAttie

State of Maryland / Department of Health and Mental Hygiene 2004 05413 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** CLYDE CALHOUN, JR. 6:50 AM 16 ERNEST 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE REHAB EXTENDED CARE BALTIMURE n/a If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F 219-07-9161 81 July Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State rai', or itams 23a or 28a-f show Examiner most be notified at 1 X Yes 2 □ No Completed by Funeral Director Maryland N/ABaltimroe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 3 any injury or other traumatic event, the Medical Extendible Invest to any injury or other traumatic event, the Medical Extendible Invest be in 351 Old Trail 21212 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Marned 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Oates: WW II Specify. white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) salesman paper goods 12 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Ernest Clyde Calhoun, Sr. Susie Collins 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Waretown, NJ 08758 18 Grand Bay Harbor Dr., Gayle Wargo/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Gar. Feb. 19,2004 Timonium, Maryland <sup>22. Name and Address of Facility</sup> Mitchell Wiedefeld Funeral Home, Inc Mitchell Baltimore, MD 21212 21. Signature of Funeral Service Licensee Inc. Mutchel Approximate Interval Between Onset and Death 23a. Int. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** STAGE DÉMENTIA resulting in death) /Medical Due to (or as a consequence of) Examiner PARKINSONS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 2 No 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Matural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 02/16/2004 057329 0, 36. Name and address of person who completed cause of death (Item 23a) (Type, Print) B1V S. Maryland 21218 Luch 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

			For State Registrar	State of Maryland / Depa	artment of Health and M rtificate of Death	1ental Hygien Reg. No	
	Physici	an	1. Decedent's Neme (First, Middle, Last,			2. Date of Death Month Da	3. Time of Death
7	/Medic		4a. Fecility Name (If not institution, give	Street and number)	4b. City, Town, or Location of Death	FEBRUCKY 13	3 200 4 11.10 AM
				Nursing Home	Baltimurs If Under 1 Year   If Under 24 Hrs.		NA
	Funeral Director		5. Social Security Number 6. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 15. Security Number 1	7. Age (In yrs. last binhday) Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year,	
	Maryland a-f ehow ified at	tor	10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits 1
	vith the	Director	10e. Street and Number		10f. Zip Code	10g. C	tizen of What Country?
9	be filed within 72 hours after death with the Maryland stal Hygiene.  do other than "neturel", or items 23s or 28s-f show event, the Medical Examinar must be mutified at	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
-003	ture!, c	ed by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	1 ☐ Yes 2 ☑ No Specify:  dent's Usual Occupation	16b. h	Specify: BIACK  Kind of Business/Industry
21215-0036	d within 72 piene. r than "ne r ne Medic	Completed	(Specify only highest grad	(Give life.	kind of work done during most of work DO NOT use retired) ACLURY WOKICER	ing	Escholy
	should be filed nd Mental Hygia marked other imatic event, II	To Be C	17. Father's Name (First, Middle, Last)  Samuel McCle.		18. Mother's Name	e (First, Middle, Maider Bell Davie	
Maryland	d 2 sho th and 7 fe ma traum	1 12	19a. Informant's Name/Relationship (Ty	rpe, Print) 19b. Maili	ng Address (Street and Number or Rur.	al Route Number, City	
Jore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	Date 20c. L	ocation - City or Town, State
Baltimore,	permit. P. Departme Important eny injury once.		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licens	7	2. Name and Address of Facility B2		
6		-	23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the death. Do not en	ter the mode of dying, such as cardiac		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	AIZhe	111 cy /s	8 caso	Onset and Death
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a consequence of):  A / A or C   En  Due to (or as a consequence of):	ota Cardiolo	n Culis 1	recas
.O. Box 68	death certific e attending p od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
S, D	Se us	by	Part II. Other significant conditions con	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
of Vital Record	e law has b	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ ✔ 6
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case reterred to medical examiner?	Janatali		(Check only one)	1
of	Phys this ral di	. To	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier  28a. Date of Injury 28b. Time o		me 5 Residence 28d. Describe how inju	
Division	ding h. Alter fune	Certification:	Natural 5 Pending investigation 3 Suicide 6 Could not be	(Month, Day Yeer) Injury  28e. Place of Injury - At home, farm, str	Work? M 1 ☐ Yes 2 ☐ No		nd Number or Rural Route Number.
á	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the		7   Notificide	building, etc. (Specify) sician: To the best of my knowledge, deat		City or Town, State	a)
	he Ho. In 24 h he Fui pletely	edical	(Check only 2 Medical Exami	ner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, date an	d place, and due to the cause(s)
<b>&gt;</b>	To the h within 24 To the F	W	29b. Signature and title of certifier	Ohe	29c. License number  D 3064		te signed (Month, Dey, Year)  hmay 172004
	4		30. Name and address of person who co	empleted cause of death (Item 23a) (Type,	Print) 169 Back	just Nec.	bray 17 200 4 1 Roug may lang
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar Signature	La.R.		

			For State Registrar	State of Man	yland / Dep	ertificate of	Health and Me Death	ental Hygie	ene 2004	0071,
	Physici /Medic Examin	al	Decedent's Name (First, Middle, L. Jeremiah     Jesten (If not institution, gi	Clar	ke,	Jr. 4b. City. Town, Baltin	or Location of Death	2. Date of Death Month February	Dey 14 Year 13 14 200 9  4c. County of Death Pal 1 1 1 money	3. Time of Death 8:45 Am
,	Funeral Director			Sex 7. Age (I	In yrs. last birthda 1 Yrs.		If Under 24 Hrs.	8. Date of Birth (Month, Day, y eb 27, 1	Baltimore 9. Births 952	olece (State or Foreign ntry)
	be filed within 72 hours after death with the Maryland tal Hyglene'd other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at	al Director	10a. State 10b. County  MD Anne 1 10e. Street and Number  29 W. Washington	Arundel	oc. City, Town or  Annapol  04			10g	. Citizen of What Cour	1 ☐ Yes 2 ☐ No  ntry?
0500-c	within 72 hours after deati ene. then "netural", or Items 2 he Medical Examiner mu	ed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13	I. Was Decedent of If Yes, specify Cul 1 Yes 2 No edent's Usual Occu	Hispanic Origin? (Specar, Mexican, Puerto For Specify:	16	14. Race - Americ Black, White, Specify: Black	etc. ICK
land 21215	be filed within 72 al Hygiene. I other than "ne vent, the Medic	Be Completed	(Specify only highest g Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Las	College (1-4or 5+) 4	(Giv	re kind of work done DO NOT use retin	a during most of working of working of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	(First, Middle, Ma	.S. Goverr	
, maryiai	s 1 and 2 should b if Health and Menti Item 27 is marked other traumatice	Tof	Jeremiah Clark 19a. Informant's Name/Relationship Ms. June K. Clar	(Турө, Print) Ке	7902	Allard (	ot and Number or Rura.	Glen Bur	reene  Sity or Town, State, Zig.  nie, MD 21  c. Location - City or To	.061
Baltimore	permit. Peges 1 Department of H Important: If Ite any injury or otl		20a. Method of Disposition  1 \( \) Burial 2 \( \) Cremation 3  4 \( \) Donation 5 \( \) Other (Spectrum 1) Determined Lice	Removal from State	Emanuel Cemete	Baptist of other pl Baptist ( ry 22. Name and Addi	Thurch Feb 20 Tess of Facility Sing	21 004 Sm gleton Fu	nithfield. Ineral Home Burnie, ML	VA e, P.A.
,	Physician /Medical		23 Pm1. Enter the disease, or co- ock, or heart failure. List onl in the state Cause (Final disease or condition resulting in death)	a Infection			ring, such as cardiac or			Approximate Interval Between Onset and Death
,/60,	te be executed ysician and eburial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a co	conseq ce of):	renal D lellitus pathy	israli			1 years 16 years un known
O. Box 68	Q 0 Q	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tin	☐ Fetal death 3	B Ectopic pregnan  Other (specify)	су		23d. Date of delive	ery Day Year
ords, P.	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions	contributing to death but i	not resulting in the	underlying cause g	iven in Part I.	23e. Did tobad	cco use contribute to to	he cause of death?
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Division of Vi	ng Phys fter this neral di	Certification: To B	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not	be Olace of Injury	Yeer) 28b. Time Injury	of 28c. Inj. W M 1	ury at 2 ork? □ Yes 2 □ No	28d. Describe how	et and Number or Rura	
<u>N</u>	To the Hospitel or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fun	Medical Certi		building, etc. (  Physician: To the best of aminer: On the basis of earth and manner state	(Specify) my knowledge, de examination and/or	ath occurred at the	time, date and place, a	ed at the time, date	se(s) and manner as s and place, and due to	o the cause(s)
•	IN A P	2	29b. Signature and title of certifler  30. Name and address of person wh			AT  e, Print) SE	2438941 LAREL 11	6 Te	bruary 13	Day, Year) 374 2004
8	St Regist	ate rar	201 I I I I I I I I I I I I I I I I I I I	22. Registrar	TRKWA 's Signature	y Bitt	D'MORE	imD,	21218	

.04		For State Registrar		artment of Health and tificate of Death	neg.	NO.
Physicia /Medic		1. Decedent's Name (First, Middle, Last, Howard F. Clar			2. Date of Death Month FEBRUARY	Day Year 3. Time of Death 13, 2004 1336 P
Examin		4a. Facility Name (If not institution, give 336 MARYDELL ROAD	·	4b. City, Town, or Location of Deat BALTIMORE CITY		4c. County of Death NOT APPLICABLE
Funeral Director		5. Social Security Number 6. Se 218-16-1168	7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign, 1924 Mary Land
within 72 hours after death with the Maryland ene. than 'natural', or items 23a or 28a-f show than 'natural' Examiner must be notified at	ctor	Usual Residence of Decedent	icable Baltimo			10d. Inside City Limit 1 ⊠ Yes 2 □ N
with the	i Dire	10e. Street and Number 336 Marydell Road	1	10f. Zip Code 21229		Citizen of What Country? United States
penint, rages I rain's anound be near while residues and deau with the wayran Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Modical Examiner is say be notified at once.	by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Amed Forces?	Mas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer t □ Yes 2점 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
sne. than "natura ta Mucilcal E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation 16a. Deced	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	. Kind of Business/Industry
dental Hygie rked other t tlc event, tt	To Be Co	17. Father's Name (First, Middle, Last)  James P. Clark, Si		18. Mother's Na	me (First, Middle, Maid d R. Schen	den Sumame)
ealth and N n 27 is me er trauma		19a. Informant's Name/Relationship (T) Ernest Clark- Bro	ther 200		Catonsvil	ty or Town, State, Zip Code) le, Maryland 21228
tment of He tant: If iter ijury or oth		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Loudon Par	sition (Name of natory or other place) rk Cemetery 2-19	-04 B	. Location - City or Town, State altimore, Maryland
Depar Impor any in once.		21. Signature of Poneral Service Ligens	110	Name and Address of Facility oudon Park Funera 520 Wilkens Avenu	l Home e, Baltimo	re, Maryland 21229
Medical and physician and street transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit trans	dicai Examiner	resulting in death)  Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			
by the attending ph tached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
been signed by should be detac	by	Part II. Other significant conditions con	ntributing to death but not resulting in the ur	nderlying cause given in Part I.		co use contribute to the cause of death?  2. ☑No 3 ☐ Probably 4 ☐Unknow
ate has	Completed				24a. Was an autopsy performed 1 🔀 Yes 2 🗆	
After this funeral di	ation: To Be	25. Was case referred to medical examiner? 1 □XYes 2 □ No  27. Manner of Death 1 ⋈ Natural 5 □ Pending 2 □ Accident investigation	All Inpatient 2 ER/Outpatien  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	t 3 DOA Other: 4 Nursing H	ath (Check only one)  lome 5 Residence  28d. Describe how in	
within 24 hours after death  To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, larm, streen building, etc. (Specify)	eet, lactory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
within 24 hours after To the Funerel Directory filled in by	edical	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exami	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	n occurred at the time, date and place restigation, in my opinion, death occu	, and due to the cause irred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
within 24 hours after To the Funerel Dir completely filled in	Me	29b. Signature and title of certifier	M	29c. License number OCME		Date signed (Month, Day, Year) BRUARY 14, 2004
011		30. Name and address of person who co		<sub>Print)</sub> an Street, Baltim	ore, Maryla	and 21201
Sta Registr		31. Date liled (Month, Day, Year)	32. Registrar's Signature	Y. Snall 3		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Da 7:00AM Physician 2A 45 EBRUARY 18 300% /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2309 HARFOR If Under 1 Year If Under 24 Hrs. MARFORD 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1**№** M 2□ F Yrs. MARYLAND 2128 387916 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits Show Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla nent of Health and Mantal Hyglene.

anir: If Heau 27 is marked other than "natural", or items 23a or 28a-1 show iny or other traumatic avent, in Marical Examine must be nullised at 1 ☐ Yes 2 No HARFORE Director MARYLAD 1- A1 2101 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code POEL (0A0) 4104 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 72000-02/01927 'IRSONARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LARRY JORIS NEIREIL 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other trai pace. 20b. Place of Disposition (Name of cametery, cramatory of other place) (090) FALLSTER ORING IARYLAND FEB 21 20c. location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State □ Donation 5 □ Other (Specify) DAR KARP 3004 22. Name and Ad ress of Facility FOD TRIS 21. Signature of Funeral Service Licenses 21234 SECO MAKEUN INCHO TERRIVIA 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiae **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner mos Caranoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 2 No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate has autopsy performed? 2 No 1 Yes 25 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 S Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 13 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after Hospitel within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated the 29c. License numbe 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 22/01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 37736 32. Registrar signature 31. Date filed (Month, Day, Year) State 20 2004 Registrar

**ORIGINAL** 

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Physicia	an	Decedent's Neme (First, Middle, Last						2. Date of De Month	Dev	Y <i>e</i> ar	3. Time of Death
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Baltimore, Mapermit. Pages 1 and 2. Department of Health at Important: If Item 27 is eny injury or other treu	PAULINE DABNEY (WIFE) 1839 W. FAYETTE 37  20a. Method of Disposition  1 Description (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)	
Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. SUBDURAL HEMATUMA  Due to (or as a consequence of):	tory arrest,  Approximate Interval Between Onset and Death  (C-2 \( \dagger \) \( \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dagger \dag
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Box ( death certif ne attending ed for use a:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery  Month Day Year
Records, P.C. In the law requires that the e has been signed by it get 2 should be detach modeleted by Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown
Vital Record  Vital Record  ician: The law requir  certificate has been s  rector, page 2 should	OF Man area referred to a refined	Was an autopsy performed?  Yes 2 ☑ No   24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
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6 2 2 2 9 O	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  Cluchouse  29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (C	tion (Street and Number or Rural Route Number, or Town, State)
To the Hospi within 24 hou To the Funer completely fill	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.  29b. Signature and title of certifier  10b. 1 7598	29d. Date signed (Month, Day, Year)
State Registrar		ALTIMORE; MD-21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 1 4 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 17, **Physician** 10:35 am Mary A. Dobry February 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ivy Hall Nursing Home Middle River Baltimore 7. Age (In yrs. last birthday) 52 yrs. 5. Social Security Number 219–60–3266 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth

Month Bay 1 (as) **Funeral** Months 1 ☐ M 2X F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore Essex 1 ☐ Yes 24 No Be Compieted by Funeral Director 10e Street and Number 919 Holgate Drive Apt. F 10f. Zio Code 21221 10g. Citizen of What Country? or Items 23a or 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 277No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes ZXNo Specify: Specify: White 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: if item 27 is marked other that any jiury or other traumatic event, Ital angles. Disabled N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles F. Dobry Sr. Thelma A. Coscia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9527 Good Spring Drive, Perry Hall, MD. 21128 19a. Informant's Name/Relationship (Type, Print) Brother Charles A. Dobry Jr. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Oaklawn Cemetery Burial 2 Cremation 3 Removal from State 2/20/2004 Eastwood, Md. 21224 \*4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Maryland 21237 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) netastatu utemie Physician /Medical Due to (or as a consequence of): Examiner Hypetensu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Drabetes Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical by the attending packed as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Joint 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 21 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Hursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral (completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 31464 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOAIB A. ItASHMI, &21 N. Sutan St Soute 308, Baltmore MD 21201

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Rnm 509'

Dobry

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2004 05421 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 23:46 M **Physician** GERALDINE DEGRAN FEBRUARY 18, 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Facility Name (If not institution, give street and number) Examiner Boldmore C/+y

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. 04/03/1936 N/AHOSPHA Johns 5. Social Security Number 220-30-7146 Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) 6. Sex **Funeral** 67 1 □ M 2√2 F Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits al Hygiene. Lother than "naturel", or Itema 23a or 28a-1 ahow went, the Medical Exercine member De notified at MD Harford Joppa 1 Yes 2 No Director 10e. Street and Number 2 Neptune Drive 10f. Zip Code 21085 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. permit. Pages t and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Iter any injury or other traumatic event, the Medical Example. ODE. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married XXMarried White Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify Specify à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Epsteins Dept Store Elementary/Secondary (0-12) College (1-4or 5+) Office Manager 18. Mother's Name (First, Middle, Maiden Surname)
Marie Naparstek 17. Father's Name (First, Middle, Last)
Clifford Gilliam P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert DeGraw 2 Neptune Drive Joppa Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State \$t.Stanislaus Cemetery 02/23/2004 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Funeral Service Licenses 1211 Chesaco Avenue Rosedale Maryland 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MPHOMA **Physician** 6 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death 5 Other (specify) the detached Physi 9 Unknown 9 Unknow signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2/3 No certificate has 2 X No 1 Yes 1 Tyes Hospitel or Attending Physicien; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗍 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifie FEBRUARY 18, 2004 KES-000 Kelman MS h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 NORTH WOLFE STEET BALTHURE MANYIAND 21287 JOHNS HOPKINS IUSTIN BENELMAN, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05422 1- For ME, G828, Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Emerick 4:58PM ichard January 10 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Northwest Randallstown Hospital Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** 10XM 20 F 69 229-36-6136 Director 19, 1934 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 or items 23a 111 Shetland Circle 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Rece - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White "naturel". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Stationary Engineer mit. Pages 1 and 2 should be filed with pertinent of Health and Mental Hygient portant: If item 27 is marked other that y njury or other traumatic event, that Real Estate 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) Be Jack Emerick Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Emerick - wife 111 Shetland Circle, Reisterstown, Md. 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gardens Jan. 13,2004 Finksburg, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Deper Import any n Health Ellet 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician >48 nour ardiogenic Shock /Medical Due to (or as a sequence of): Examiner Myocardial intarcti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): 10N APOROVED BY MEDICAL EXTMINER burial-transit Physician: The law requires that the death certificate be executed Joronary art and physician P.O. Box 68760 Physician/Medical the as the attending IF FEMALE: use a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 212 No failure Chronic renal Cerebrovascular 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death

1-Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 or Attending 5 Pending triknown p<sup>M</sup> subject fell 1 ☐ Yes 2 No investigation XXAccident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office houlding, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 111 shetland Circle, Reisterstown, MD To the Hospital e within 24 hours at To the Funerel D 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 028462 10,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown, Maryland 21133 tor Center Northwest Hospita 31. Date filed (Month, Day, Year) FEB 2 0 2004 32. Resistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of	Maryland	/ Depa	artment of F	lealth a Death	and Ment		ene 2	004	05424	
	15/3-		1. Decedent's Name (First, Middle							ate of Death	Day	Year	3. Time of Death	
	Physici /Medic		Roser	mary T.	Franz					oruary		2004	4:45 A M	
1	Examin		4a. Facility Name (If not institution	, give street and nun	nber)		4b. City, Town, o				4c. County of Death			
1, 12	We.		Rose Manor				Ellicot		Lty		How	ard		
	Funeral Director		5. Social Security Number 304-07-6608	6. Sex 1 ☐ M 2XX F	7. Age (In yrs. Ias 86	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (A	ate of Birth Month, Day,	<sup>Year)</sup> 1917	Соц	place (State or Foreign ntry) iana	
	p Pu		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits	
	sho	ä	Maryland Howai	Бъ								1 ☐ Yes 2 ☑ No		
	28a-f	ect	10e. Street and Number	La	1	PITIC	10f Zip Code			10	o Citizen o	of What Cou	ntry?	
	with a or	ă	3100 North Rid	ge Road			2104	13				ted S	•	
	ns 23	era	11. Marital Status	12. Was Dece	dent Ever in U.S.	13.	Was Decedent of H		igin? (Specify Y	es or No-		lace - Ameri		
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Erain, natural be indiffed at	by Funeral Directo	1 Never Married 2 Married 3 25Widowed 4 Divorced	Armed For	2 (ŽÑNo e		f Yes, specify Cubi 1 □ Yes 2 🗷 No	Specify:		, etc.)	Spec	lack, White,	etc. hite	
21215-0036	thon stura	ed	15. Decedent	's Education			dent's Usual Occup			1	6b. Kind of	Business/Ir	ndustry	
215	n n	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed) College (1	-40(5+)	(Give	kind of work done DO NOT use retired	du <i>ring</i> mos d)	t of working					
27.	r the	E O	12	College (1	401 547		Homemake	r			C	wn Ho	me	
פ	e filed Il Hygi other	Bec	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name <i>(Fir</i> s	t, Middle, M	aiden Sum	ame)		
ā		10 E	William Rapp					Ros	salie Ti	ittel				
Maryland	s 1 and 2 should if Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rural Rou	te Number,	City or Tou	vn, State, Zij	Code)	
	and 2 ealth in 27 I		Pete Franz - So	on			Poplar A	venue	e Arbut	us, M	aryla	nd 21:	227	
ore.	of He of He r oth		20a. Method of Disposition 1 □ Burial 2 A Cremation	3 Permoval from 1	Сел	netery, crei	sition (Name of natory or other plac		Date		Oc. Locatio	n - City or T	own, State	
Ĕ	Pages nent of ant: If it ury or o		'4 □ Donation 5 □ Other (S)		Balt		sh. Crema					, Mar	,	
Baltimore,	permit. Pages Department of t Important: If ite any injury or of once.		21. Signature of Funeral Service	Licensee	$\sim$	G2 72	Name and Addre ary L. Ka 250 Washi	ss of Facilit ufman noton	Funera Blvd.	al Hom	e At	MMP.,	Inc. land 21075	
1			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that comply one cause on a	aused the death.							11012	Approximate Interval Between	
-	Physician		Immediate Cause (Final disease or condition		ROSCLER.	\$10	CARDIO,	(A (	7	16-216	<i>_</i>		Onset and Death	
	/Medical		resulting in death)		or as a conseque		(MICO)	NJCV		756 113	•		75/11-5	
*	Examiner		Sequentially list conditions,	b										
- 3	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a conseque	nce or):									
	and trans	cam	that initiated events resulting in death) Last	nce of):						-				
760,	ate be executed hysician and the burial-transit													
ထာ	phys phys the	edical		d										
× 6	death certificate be executed e attending physician and id for use as the burial-transit	/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnanc						23d. [	Date of deliv	erv	
Вох	eath atter	Physician/M	in the past 12 months?		irth 2  Fetal de ant at time of dear		Ectopic pregnancy Other (specify) _					Month	Day Year	
o.	at the de by the	hysl	9 Unknown	9□ Unkno	own									
<b>.</b> .	The law requires that the tee bas been signed by thoage 2 should be detache	by P	Part II. Other significant condition	ons contributing to de	eath but not resulti	ng in the u	nderlying cause giv	en in Part I	. 2	3e. Did toba	cco use co	ontribute to t	he cause of death?	
ğ	w require been sig should b						,			1 🗌 Yes	2 ₫110	3 Pro	oably 4 Unknown	
Records,	aw re	Completed							2	4a. Was an autopsy	241	b. Were auto	opsy findings available impletion of cause of	
	The lav ate has page 2	E o							1	perform	ed?	death?	2 □ No	
ita	ysiclan: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?					26. Place	of Death (Che					
<u>&gt;</u>	Physiclan: r this certific ral director,	2	1 Yes 2 No			VOutpatier		4 🗀 NU	ursing Home	5 🗌 Residen	се 6 🔎	ther (Span	MY CININA	
ū	ding P. h. After t funera	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pendin	9	of Injury h, Day Year)	8b. Time o Injury	Wor			Describe hov	v injury occ	urred		
Sio	Attending er death. rector: After by the fune	cati	2 Accident investig	not be	111			Yes 2		.: (0:				
Division of Vital	or At	Certification;	4 Homicide determ	ined 286 Place	of Injury - At homing, etc. (Specify)	e, farm, str	eet, factory, office		28f. L	cation (Stre lity or Town,	State)	mber or Hur	al Route Number,	
<	Hospital 14 hours a Funeral I	i C	29a. Certifier 1 Certifyin	g Physician: To the	hast of my knowle	edge dest	noccurred at the to	ne data an	nd place, and di	ue to the ac-	100(0) 000	manner co	tated	
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director:	edicai	(Check only 2 Medical one)	Examiner: On the ba and mann	asis of examination	n and/or in	vestigation, in my o	pinion, dea	ath occurred at	the time, dat	e and place	e, and due t	o the cause(s)	
	To the within 2 To the comple	ž	29b. Signature and tyle of certified				29c. Licens				_	ned (Month,		
			1 492	M	)		Ds	-186	0	1	FEB	20.	2004	
	20		30. Name and address of person	who completed caus	e of death (Item 2	За) (Туре,	Print)						2004 , MD 2/044	
	0		Jo		FIJH MO	/0	700 CHA.	MEN	DRIVE	#200	Coc	MIGIA	Thous ON	
	Sta		31. Date file ( Dath, Bay) Year	04 32. R	egistrar's Signatui	· Sou	23							
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#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05425 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Feb Flynn 04 4:00 AM BriBN Martin 15 4c. County of Death 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) Ellicott City 3349 North Chatham Rd apt A. Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth House Hours Min. (Month, Day, Yeer) 9. Birthplace (State or Foreign Country) Many land 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months 1 MM 2□ F 65 Yrs. 216-34-2968 9 1938 Usual Residence of Decedent 10c. City, Town or Location 10d. Insida City Limits 10a. State 1 ☐ Yes 2 No MO Howard Ellicott Cit 10g. Citizen of What Country? USA 21042 3349 North ChatHam Rd, Apot A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 M(Yes 2 □ No HYes, Give Yeer or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automoti Ve Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Violet John Thomas Margaret Davidson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2923 Toddsbury Court Abington MD 21009 Joan K. Jones 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 25.04 Balta. MD Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald to arayson Funeral Home 108 W. north ave. Balturne, MD Kinald Cithaupon 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chronic Ohn tructure Pulmonay Di scare Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of

Examine sician and a bunal-transit Attending Physician: The lew requires that the deeth cartificete be executed physician as the burial Division of Vital Records, P.O. Box 68760, Certification: To this : Aftar this i Director: A sid in by that

**Physician** 

Examiner

**Funeral** 

Director

r than "natural", or flems 23a or 28a-f the Medical Examiner must be notifie

and Mental Hygian

of Haelth

**Physician** 

/Medical Examiner

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filad within 72 hours after death

Pegas 1 and 2 should be

altimore, Maryland 21215-0020

/Medical

Directo

Funeral

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Completed

Be

Physician/Medical ð Completed Be

within 24 hours after or To the Funeral Direct complately filled in by

To the Hospital

1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

3064-1

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Sabapathi

. Registrar's Signature

lan

3 400 Excluser Avenue BATIMORE Mary Calliers

State

DHMH 16 Rev 6/95

			1 - For State RegistrarAMEND ITEM #8 1	State of PER FH G8	Marylar 328 2/24	nd / Depa /04 அ <i>செ</i>	artment of rtificate of	Health a Death	and Me		iene 2 0	104	05426
			1. Decedent's Name (First, Middle, Last			,			-	2. Date of Deat	h		3. Time of Death
	Physici /Medic		Helen Lee France-1	Kelly						Feb. 18	Day 3. 2004	Year	2:38 P M
1	Examin		4a. Facility Name (If not institution, give	street and num	nber)		4b. City, Town,	or Location of	of Death		4c. County		
			719 Maiden Choice				Caton	sville			Balt	imore	
	Funeral		5. Social Security Number 6. Se	× ∃M 2□√F   7		last birthday) Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Birth (Month, Day,	$\frac{9-1915}{Y_{\theta ar}}$		place (State or Foreign htry)
	Director		577–20–7516  Usual Residence of Decedent	X	88	110.				9ct. 9,	<del>-1915</del> _	Kent	ucky
	yland Iow	Ì	10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					1	0d. Inside City Limits
	Mar.	to	Maryland Baltimon	ce		Catons	ville						1 ☐ Yes 2 No
	n with tha 3a or 28a st be not	al Director	10e. Street and Number 719 Maiden Choice	Lane, 1	BR 231		10f. Zip Code 21.	228			0g. Citizen of What Country? USA		
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Martel Hygiene. Item 23 is marked othar than "naturel; or Items 23a or 28a-f show othar than "naturel" or Items 23a or 28a-f show othar treumetic event, the Marical Evaninal for Intilified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1  Yes 2 If Yes, Give Year or Dat	ces? 2 No 3 X	ļ l	Vas Decedent of f Yes, specify Cu I ☐ Yes 2 No	ban, Mexicar	igin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		ce - Americ ck, White,	
ğ	2 hou	ed	15. Decedent's Edu	ıcation		16a. Deced	lent's Usual Occi	pation			16b. Kind of B		
212	nin 72 In "m	ple	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-	4or 5+)	(Give	kind of work don OO NOT use retir	e during mos ed)	t of workin	g			,
21	od witi	Completed by	Elementary/decondary (0 12)	+5	401 347	Н	omemake	r			Own h	ome	
Maryland 21215-0036	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle, M	faiden Surnar	ne)	
yla	Mant Mant arked etic e	2	Francis Aloysius H	legarty				Cla	ra An	nunciat	a Dono	hoe	
ar	2 she and is m		19a. Informant's Name/Relationship (T)			1	g Address (Stree						•
<u>6</u>	es 1 and 2 of Health of filem 27 i		Kenneth A. France-	-Kelly /			E. Stree	et St.					
Baltimore,	if ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F			cemetery, cren	sition (Name of natory or other pl	ace)	Da	10 2	0c. Location	City or To	wn, State
Ë	permit. Pa Departmen Importent: any injury	1	`4 □Donation '5 □ Other (Specify)		Ba		Cremato	-	2/20/				Maryland
Bal	permit. Pages Department of t Importent: If ite any injury or of once.		21. Signature of Funeral Service Licens	and			Name and Add		110	bbard F , Balti	uneral more, 1	Home Md. 2	, Inc. 1229
	Physician	8 W	23a. Part1. Enter the disease, or compl shock, or heart failure. List only o immediate Cause (Final disease or condition	ne cause on ea	used the deat ch line.		er the mode of dy		cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	d	or as a consec		Cino	7120					
-	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, [Disease of injury]	Due to (or as a consequence of):									
8760,	cate be exacuted physician and the burial-transit	I Examiner	that initiated events resulting in death) Last	quence of):									
387	physics the t	dlcal	d.										· · · · · · · · · · · · · · · · · · ·
.O. Box 6	The law requires that the death certificate has been signad by the attending sage 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 WNo 9 □ Unknown		□Ectopic pregnancy □ Other (specify)				23d. Date of delivery Month Day Year				
۵.	that the	H.	Part II. Other significant conditions co	ntributing to dea	ath but not res	sulting in the un	derlying cause g	ven in Part I.		23e. Did tob	acco use cont	ribute to th	e cause of death?
g,	uires signa d be									1 ☐ Yes	2 □ No	3 Proba	ably 4 🗖 Unknown
Ö	w requir been s should	lete						<del></del>		24a. Was an	24h 1	Nere autor	nsy findings available
Re	The lav	ompleted								autopsy perform 1 Yes 2	ed?_ (	prior to con death?	osy findings available inpletion of cause of
<u>ra</u>		BeC	25. Was case referred to medical					26. Place	of Death (	Check only one			20110
<b>&gt;</b>	Physician: this certific ral diractor,	2	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ☐ Inj	patient 2	ER/Outpatient	3□ DOA O	her: 4 □ Nui	rsing Home	5 PResider	nce 6 □Oth	er (Specify	)
Division of Vital Records,	Attending Ph ir death. ector: After th by the funeral	atlon:	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of (Month)	Injury , Day Year)	28b. Time of Injury		ıryat ork? ]Yes 2 ∐î	100	d. Describe how	v injury occurr	ed	
Divis	al or Atten s after deat I Director: d in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place o building	of Injury - At he g, etc. <i>(Specit</i>	ome, farm, stre	et, factory, office		28	f. Location (Stre City or Town,		er or Rural	Route Number,
	Hospi 4 hou Funer ely fill	edical C	29a. Certifier 1 Certifying Physical Control (Check only one)	sician: To the b ner: On the bas and manne	SIS OF BYAINING	owledge, death ation and/or inv	occurred at the t estigation, in my	ime, date and opinion, deat	d place, an	d due to the car I at the time, da	use(s) and ma te and place, a	nner as sta and due to	ated. the cause(s)
	To the I	Me	29b. Signature and title of certifier				29c. Licen	se number		29	d. Date signed	(Month, L	Day, Year)
	1		Mener Bor	wlin	, mes		244	377	<b>)</b>		2/1	9/0	4
	22		30. Name and address of person who co				Print)						-1
	0			10, 7	11 Ma	iden	Choice	Lane	, Cu	tonsvill	e, m	0 2	21228
	Sta Registra		31. Date filed (Month, Day, Year)	32.	gistrar's Signa	ature	est?		1				

State of Maryland / Department of Health and Mental Hygienea a a l

			1 - For State Registrar AMEND ITEM #18	3 PER FH G828 2/20	)/04 <b>G</b> F	ertificate of i	Death	Reg. No	2004	05421
			1. Decedent's Name (First, Middle, Las		•			2. Date of Death Month Da	y Year	3. Time of Death
4	Physici /Medio		ELIZ	ZABETH		FELDMAN	FELDMAN FEBRUARY 15, 20			10:30 P <sup>M</sup>
The same	Examin		4a. Fecility Name (If not institution, give				Location of Death	40	. County of Death	
			JEWISH CONVALESO			BALTIM If Under 1 Year	ORE	1 0 Days of Birth	BALTIM	
	Funeral Director			ex 7. Age (In yrs. 96	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Year) MAR 14, 1	907 N	place (State or Foreign ntry) IARYLAND
and	M =		Usuel Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or	Location				10d. Inside City Limits
Mary	H B	ō	MD BALTIMO	ORE	ВA	LTIMORE				1 ☐ Yes 2 🙀 No
the	128a	Jec.	10e. Street and Number			10f. Zip Code	· · · · · · · · · · · · · · · · · · ·	10g. Ci	tizen of What Cou	ntry?
th wit	23a o	Funeral Director	11 SLADE AVE., A	PT. 915		2	21208	US	A	
rdea	eme sr m	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 1	<ol><li>Was Decedent of H If Yes, specify Cuba</li></ol>	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	<ol> <li>Race - Ameri Black, White,</li> </ol>	
1 21 5-0036 within 72 hours after death with the Maryland	ial Hygiene. d other than "naturel", or lieme 23a or 28a-f ehow event, the Medical Examiner must be notified at	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1□ Yes 2□XNo	Specify:		Specify: WHI	TE
2 2 4 5 4 5 4 5 4 5 4 5 4 5 4 5 4 5 4 5	"natu	Completed	15. Decedent's Ed (Specify only highest gra		(G	cedent's Usual Occup ive kind of work done o b. DO NOT use retired	during most of work	ing 16b. K	and of Business/Ir	dustry
within	then.	du	Elementary/Secondary (0-12)	College (1-4or 5+)			•	67.	18.T LIOCE	
<b>N</b> 0	Hygi ther int, I	ပိ	17. Father's Name (First, Middle, Last)		L REC	ORD LIBRAR		e (First, Middle, Maider	AI HOSP.	
Maryland d2 should be fife		To Be	HYMAN	MI	LLER		SARA	H FEINBERG	FRIN	BERG
shou	f Health and Meritem 27 is market other traumatic	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Ma	ailing Address (Street	and Number or Rur	al Route Number, City	or Town, State, Zij	Code)
	27 lin		ALICE RADMAN (SI	STER)	360	1 CLARKS L	A., APT.	601 BALTO	., MD 21	215
ore,	of Hear fitem r othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		lace of Dis	sposition (Name of rematory or other place		Date 20c. L	ocation - City or T	own, State
Baltimore, permit. Pages 1 a	ant: I		*4 □Donation 5 □ Other (Specify	2 / 1	HIZUK			2/17/04 B		
Salt ermit.	Department of Important: If it any injury or one		21. Signature of Juneral Service Licen	see		22. Name and Addres		L LEVINSON		
n e			MUMOUS	Muger	b D			ROAD - PIK	ESVILLE,	MD 21208 Approximate
1 m			23a. Part . Enter the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, or composition for the disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, disease, dise	one seuse on each line.	n. Do not	enter the mode of dyin	TO FO	e VAScelt	20 1	Interval Between
<i>e</i>	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	. ATHEROS		wile C	CKUDA	5 VASCUL	177 1713	EHSE
	xaminer			Due to (or as a conseq	uence of):					
16.	<	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):					
petno	ansit	Examiner	Cause (Disease or injury that initiated events	C.						
O,	en ar irial-ti		resulting in death) Last	Due to (or as a conseq	uence of):					
. Box 68/60, death certificate be executed	ng physicien and as the burial-transit	Wedical	•	d						
ertific	ding p		IF FEMALE:	O2s If use subserve of second						
BOX Bath Ce	attendir for use	Physician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of deliv Month	ery Day Year
S S	by the a	ysło	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9☐ Unknown	oatii	Other (specify)				
Hecords, P.O.	igned by be deta		Part II. Dther significant conditions of	ontributing to death but not res	ulting in the	underlying cause give	en in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
ecords,	n sign	d by				_		1 ☐ Yes 2	□No 3□Prot	pably 4 Donknown
Ö ≥ ≥	s peen si should	Completed						24a. Was an	24b. Were auto	ppsy findings available
F 5	page 2	mo						autopsy performed2	death?	mpletion of cause of
		Be C	25. Was case referred to medical				26. Place of Deat	n (Check only one)		
JIVISION OF VITA or Attending Physician:	this ce al direc	To	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpat	ient 3 DOA Oth	4 Nursing Ho	me 5 Residence	6 ☐Other (Specia	(y)
_ 20 P	h. After th tuneral		27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injur	y Worl		28d. Describe how inju	ry occurred	
DIVISION I or Attending	tor: A	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No	204 Lacation (Ctanada	- 1 N	1. Courte Africa hor
S S	Direction by	Certification;	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)	street, factory, office		28f. Location (Street ar City or Town, State		I Aoute Multiper,
Sign Sign	hours after deat uneral Director: ly filled in by the		29a. Certifier Certifying Ph	ysician: To the best of my kno	wiedge, de	eath occurred at the time	ne, date and place.	and due to the cause(s	and manner as s	tated.
ě.	Full Full letely	Medical	(Check only 2 Medical Examone)	niner: On the basis of examina and manner stated.	tion and/or	investigation, in my o	pinion, death occur	red at the time, date and	d place, and due to	the cause(s)
To the	within 24 ho To the Fune completely f	W	29b. Signature and title of certifier			29c. Licenso		29d. Da	te signed (Month,	Day, Year)
	į.		Jasneu	Valelia	ni	1)28	395	2	16/04	
	6		30. Name and address of person who	completed cause of death (Item	7 23a) (Typ	De, Print) PAR	2k HEI	GHTS AN	E. BAC	10/4/21/20
#h	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture	0 0.				
		ar	FEB 2 0 20	04 Brown A	150	Carried P				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4

			1 = For State Registrar	State of Mary		ertificate of		iental Hygiei 	4004	05428
	Physici	an	1. Decedent's Name (First, Middle, Las	" R F	rank	lin		2. Date of Death Month	Day Year	3. Time of Death
*	/Medio Examin		4a. Facility Name (If not institution, give	nor NSq.	Home	4b. Cily, Town,	or Location of Death	rebruary	4c. County of Death	more.
	Funeral Director		5. Social Security Number 6. St 2 3 - 14 - 2532 1  Usual Residence of Decedent	ex 7. Age (Ir ☐ M 2 D(F	yrs. last birthday Yrs.	Months Days		8. Date of Birth (Month, Day, Ye	ar) 18 MCon	nplace (State or Foreign untry)
	Maryland B-f show iffed at	tor	10a. State 10b. County Maryland Parti	more 10	c. City, Town or I	ocation				10d. Inside City Limits 1 Yes 2 □ No
	ath with the 23a or 28 ust be not	Funeral Director	10e. St/eet and Number 3803 Cord	nado C	ircle	10f. Zip Code	244		Citizen of What Co	untry? A
036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow he Medical Examinar must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Evel Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	r in U.S. 13	. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Giv	edent's Usual Occu te kind of work done DO NOT use retire	during most of work	ing 16b	Kind of Business/I	ndustry
yland 2	should be filed nd Mental Hygin marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last)	brooks			Mary	(First, Middle, Maid Walk	Ker	
-	s 1 and 2 sho Health and tem 27 is m other traum		19a. Informant's Name/Relationship (1)  Nr. James F  20a. Method of Disposition	ranklin	Ob. Place of Disp	ling Address (Street  Consition (Name of ematory or other pla	conado	Al Route Number, Cit	ty or Town, State, Z	Md. 2124
<b>Baltimore</b> ,	permit. Pages 1 a Department of Hea Important: If item any injury or othe once.		1 ⊠ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen	)	Noodla	1	ery 2/21	2004 W Funeral	bodlan Home	in, Md.
\$1			23a. Part J. Enter the disease, or company to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the c	plications that caused the one cause on each line.	death. Do not e	nter the mode of dy	Nor The A	or respiratory arrest,	Ito. Ma	Approximate Interval Between Onset and Death
Å	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a co	onsequence of):	01 3109	Some	191		Un keurin
68760,	tificate be executed ig physicien and as the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
.O. Box 68	death cer e attendir id for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mowths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify) _	у		23d. Date of delh Month	very Day Year
Δ.	w requires that the s been signed by th should be detache	by	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the	underlying cause gr	ven in Part I.	23e. Did tobacc		the cause of death?
of Vital Records,	The law ate has b page 2 sl	Completed	1	Di bete				24a. Was an autopsy performed 1 Yes 2 12	prior to c death?	topsy findings available ompletion of cause of
Vita	sician: certific rector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 C E D/O-1	3E po. 0	hor	(Check only one)		
	ding h. After fune	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpati 28b. Time Injury	of 28c. Inju	-	me 5 Residence 28d. Describe how in		ity)
Division	p ag ig ⊡	Certification;	3 Suicide 6 Could not be determined	building, etc. (S	Specify)			28f. Location (Street City or Town, St	tate)	
	ne Hospital n 24 hours a ne Funeral Dietely filled	edical	29a. Certifier 1  Certifying Ph (Check only one) 2  Medical Exam	ysician: To the best of m niner: On the basis of ex- and/manner stated	mination and/or	ith occurred at the ti investigation, in my	ime, date and place, opinion, death occurr	and due to the cause ed at the time, date a	i(s) and manner as and place, and due	stated. to the cause(s)
		Me	29b. Signature and title of certifier	At ,	MD		se number ) 27 569		Date signed (Month 2/17/04	, Day, Year)
	10		30. Name and address of person who	Impleted cause of death		B& Great	27569 reme Tree	Rd	21208	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's		raff o	1			

			For State Registrar	State of Maryland	/ Department of Health and N Certificate of Death	ntal Hygier Reg. t		05429
			Decedent's Name (First, Middle, Last)		1.1	2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Mary	titzge	4b. City, Town, or Location of Death	Jebruary,	15, 2004 4c. County of Death	9:00 AM
	Examin	er	4a. Facility Name (If not institution, give s	- Hospit	al Baltimore		NIA	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (Inlyrs. last	t birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp	lace (State or Foreign try)
	D	4	Usual Residence of Decedent			Dec. co, 1	130 VII	J
	J within 72 hours after death with the Maryland jiene. I than "natural", or Items 23e or 28e-f show I're Madical Exertirer and be notified at	tor	Maryland NA	10c. City, T	own or Location			0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the 3a or 286	I Director	10e. St/eet and Number	nor St	10f. Zip Code	10g. (	Citizen of What Coun	atry?
	ems 2	Funeral	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
036	al', or it	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 ØNo Specify:		Specify: Blo	ack
215-0036	"natur	eted	15. Decedent's Educ (Specify only highest grade		Ba. Decedent's Usual Occupation     (Give kind of work done during most of work life. DO NOT use retired)		, Kind of Business/Ind	dustry
212	y within piene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Unemployed		Disabi	led
Maryland 3	ould be filed Mental Hygi erked other letic event, II	Be	17. Father's Name (First, Middle, Last)	zaorald	18. Mother's Nam	e (First, Middle, Maid	en Sumame)	<del>(</del>
aryl	de la la	٦	19a. Info mant's Name/Relationship (Type	oo, Prior (mother)	19b. Mailing Address (Street and Number or Ru	ral Route Number, Cit	y or Town, State, Zip	Code)
	s 1 and 2 if Health a Item 27 is other tre		Mrs, Flura ( 20a, Method of Disposition	liver 200, Plac	245 2 K CK y Tora	Date , 20c.	Location - City or To	4, 2, 373 () own, State
altimore	Se to Te		1 Surial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)		etery, crematory or other place)	21/2004 /	1 reule.	1)a.
Baltir	permit. Pag Department Importent: I any in ury o		21. Signature of Funeral Service Lice Ise	Russ	22. Name and Address of Facility  Joseph L. Russ	Funera	y Home	12.12.16
г			23a. Parth. Enter the disease, or compliant or heart value. List only on	ations that caused the death.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	2(10:10)	Approximate Interval Between
}	Physician		Immediate Cause (Final disease or condition	Metastanc	Kenal Carcinoma			Onset and Death
	/Medical Examiner		resulting in death)	Due lo (or as a consequer	nce of):			
-	ed	ılner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	nce of):			
ó	sate be executed only sician and the burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequer	nce of):			
8760,	ate be	lcal						
9	leath certific attending pl	/Мес	IF FEMALE: 23b. Was decedent pregnant 2:	3c. If yes, outcome of pregnance			23d. Date of delive	ery
D. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/Medical	in the past 12 months?  1 ☐ Yes 2 ဩ No 9 ☐ Unknown	1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown			Month	Day Year
, P.O	es that the de igned by the a be detached f	by Phy	Part II. Other significant conditions con	tributing to death but not resulti	ng in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to th	ne cause of death?
rds	w requires been sign should be	ted b				1 Tes	2 StNo 3 Prob	ably 4 Unknown
of Vital Records,	The law re ate has be page 2 sh	Completed				24a. Was an autopsy performed	? prior to cor death?	psy findings available impletion of cause of
ital	sicien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?		The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	th (Check only one)		
of V	Physicien: r this certifica ral director,	မ	1 ☐ Yes 2 ②No  27. Manner of Death		VOutpatient 3□ DOA Other: 4□ Nursing H	ome 5 Residence		y)
ion	Attending In death.  ector: After by the funer	atlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Work? M 1 ☐ Yes 2 ☐ No			
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rura tate)	il Route Number,
, -	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ledical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examination	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place n and/or investigation, in my opinion, death occu	, and due to the cause rred at the time, date :	e(s) and manner as st and place, and due to	tated. the cause(s)
	To the within :	Mec	29b. Signature and title of certifier	.00 1 11	29c. License number	29d.	Date signed (Month,	Day, Year)
	Λ		* HIMOUSUN 2	Medical House	Oficer 145148	H	bruary, 15	10 2004
	<b>5</b>		RICARDO OSURNIO	mpleted cause of death (Item 2 2000 MUST B	altimore Street. Bultimo	ice. Marylar	nd-21223,	Hospitzu
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  FFR 2 0 2004	32. Registrar's Signatur	Joseph .			

			For 1 State	• •	k Indelible Ink. Ensure A Department of Health and N Certificate of Death	Mental Hygie	ne <b>20</b> 04 05430
	Physici		Registrar  1. Decedent's Name (First, Middle, Last	ARREN KETT		2. Date of Death Month FEBRUARY	Day Year 11 O4 PM
	/Medio Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death
	Funeral Director		5. Social Security Number 6. S 214.90.2700			8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign
	Maryland f show	JO.	Usual Residence of Decedent  10a, State  10b, County	10c. Sky, Tow DAL	n or Location		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	uth with the Maryland 23a or 28a-f show ust be notified at	Funeral Director	10e. Street and Number 1420 GITTING	as AVE.	10f. Zip Code 21239	10g.	Citizen of What Country? U.S.A.
936	after dea or Itams miner m	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	swithln 72 hours jiene. r then "neturel", ine Molcal Ex	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)		EOOD
	be filed tal Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last) WAYNE	Scott	18. Mother's Nam	den Sumame) EREBEE	
, Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship ( BERTHA MAE FET	/ 12	Mailing Address (Street and Number or Ru 420 G1H1NGS AVE.	BACTIMOR	ity or Town, State, Zip Code) LE, MALYLAND 21239
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2' any Injury or othar once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Specification)	Removal from State CARR		24.04 01	C. Location - City or Town, State  UNGS MILLS, MARYUNI
Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Licer	oxh dreese	22. Name and Address of Facility VA 4905 YOKK RDAD	BACTIMO	REENE FUNELAL HOME RE, MARYLAND 21212
	Pnysician /Medical Examiner	er	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	plications that caused the death. Do one cause on each line.  a. CRAM NEGA:  Due to (or as a consequence)  Due to (or as a consequence)	of):	or respiratory arrest,	Approximate Interval Between Onset and Desch
60,	be executed sician and burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	of):		
P.O. Box 68760,	death certificate e attending phys id for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	n 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
	ires that the signed by	by Pł	Part II. Other significant conditions of PANCY TO PENIA			23e. Did tobac	co use contribute to the cause of death?
Division of Vital Records,	law requase been 2 should	Completed by	HYPOTHY ROLDISA			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ital	ysician: The Is certificate hadirector, page	Be Co	25. Was case referred to medical examiner?			th (Check only one)	No 1 □ Yes 2 □ No
of <	Physic this ce al direc	은	1 Yes 2 No		· · · · · · · · · · · · · · · · · · ·	ome 5 Residence	e 6 Other (Specify)
ion	ling I. After fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Time of Injury at Work?  M 1 Yes 2 No		
Divis	al or Atter after de I Directe d in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined		arm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, Itate)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 11x Certifying Pl (Check only 2 Medical Exa- one)	nysician: To the best of my knowledg miner: On the basis of examination a and manner stated.	e, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
<b>)</b>	To the within To the comple	Me	29b. Signature and title of certifier	МО	29c. License number	29d.	Date signed (Month, Day, Year)
	1		30. Name and address of person who IZUKANJI SIKAZU	completed cause of death (Item 23a) E, 5601 LOCH RA	(Type, Print) GOOD SP VEN BLVD. BALTINO	MARITAN RE 2123	HOSPITAL 6 MD

State Registrar 31. Date filed (Month, Day, Year)
FEB 2 0 2004

32. Registrar's Signature

Sparks

			For State	State of Maryland / De	partment of Health and I Pertificate of Death		ene 2004	05431			
			Registrar  1. Decedent's Name (First, Middle, Last,			2. Date of Death Month	Day Year	3. Time of Death			
	Physicia /Medic		BESSIE	647	<b>y</b>	02	6 2004	1/35 P.W			
	Examin	er	4a. Facility Name (If not institution, give	11 m A .	4b. City, Town, or Location of Death		4c. County of Death	LA			
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24 Hrs.	_ (Month, Day, Y	ear) Cou	nplace (State or Foreign untry)			
	Director		Usual Residence of Decedent	M 28 Y Yrs		SEPT 10, 1	1916 VI	RGINIA			
	show show		10a. State 10b. County	10c. City, Town or	•	d ,		10d. Inside City Limits			
	ours after death with the Maryland rai', or itams 23e or 28a-f show Examinar must be notitived at	Funeral Director	MARYLAND N/	A	BALTIMORE 101. Zip Code	City	. Citizen of What Cou	1ÆYes 2□No			
	23e or 2	i Di	10e. Street and Number	ESIDE AVENUE		7	USA				
	ter death	nera	11. Marital Status		Was Decedent of Hispanic Origin? (S     If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	rican Indian,			
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Ē	Pages nent of int: ff it iny or o		1 Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State	crematory or other place) US (RMETERY 02 - 1	21-04 E	BALTIMO	RE MARULAND			
2	permit. Departm Importa any inju		21. Signature of Funeral Service Licens		22. Name and Address of Recility	BROWN	TR. FUNE	eral Home			
D	20 E 2 9	1 (3)	Withich N	Enations that caused the death. Do not	2140 N. FULTO enter the mode of dying, such as cardial			PE, MO 2/2/7			
			shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.			,	Interval Between Onset and Death			
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as a consequence of):	YOCARDIAL	IN F AR	CHON				
	Examiner		Sequentially list conditions.	b							
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0/9	cate be executed physician and the burial-transit	dical		d							
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gox	death certific e attending p id for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	4.450	Month	Day Year			
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UIVISION	al or Attandir safter death. I Director: Al d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	rai Route Number,			
ם	pital o		29a. Certifier 1 Certifying Phy	reicien. To the best of my knowledge of	leath occurred at the time, date and place	and due to the cau	se(s) and manner as	stated			
	a Hos 24 hc e Fun letely	edical		iner: On the basis of examination and/o and manner stated.	or investigation, in my opinion, death occu	urred at the time, date	e and place, and due	to the cause(s)			
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Me	29b. Signature and title of certifier	12.1	29c. License number	290	I. Date signed (Month	n. Day, Year)			
	-		1 Smill	, vui	V50272	. 0	2/16/2a	ty			
	·X		30. Name and address of person who o	ompleted cause of death (Item 23a) (Ty	29c. License number  D30272  TPE. Print)  BON SETTURS	HOSPITA	I BACT	more MD			
	Sta	te	31 Date filed (Month, Day, Year)	32. Pegistrar's Signature	A						
	Registi	ar	FEB 2 0 2	104 Marie 15	Market !						

State of Maryland / Department of Health and Mental Hygiene 05432 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death **Physician** / Month Manhart Latci Galambos /Medical 4c. County of Death 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RFORM 5. Social Security Number It Under 24 Hrs If Under 1 Year 7. Age (In yrs. lest birthday) **Funeral**  Birthplace (State or Foreign Country) Days Months Hours 1 M 2 □ F 192-20-6692 Director 76 1927 Pennsylvania Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylend nent of Haath and Mantel Hygiana. Int: If Item 27 is marked other than "natural", or items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Haath and Mantel Hygiana. Important: jor items 23a or 28a-f sho any injury or other traumatic event, the Medical Examinar must be notified at Maryland Harford Be Completed by Funeral Director Joppa 1 ☐ Yes 2√2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 509 Grigsby Court 21085 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical 4 U.S. Postal Service 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephan (NMN) Galambos Julia (NMN) Toth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Kathleen M. Galambos/Wife 509 Grigsby Court, Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Lutheran Cem. 2-19-04 Joppa, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. w 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that cause the period of the period of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner The law requiras that tha death certificeta be executed buriel-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? nous disone, Reportousian paga 2 s has 25. Was case referred to medical examiner? 2 DA 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completaly filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 2 Accident 1 Tyes 2 No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours e To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 2004 State Registrar

ORIGINAL

of Vital Records, P.O. Box 68760,

Division

**DHMH 16 Rev 6/95** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05433 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** GIBSON c lyde 1:46 AM 2004 FEBRUARY 17 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE JOHNS HOPKINS HOSPITAL 8. Date of Birth (Month, Dey, Year)

Jan. 26, 1929 South Carolina If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F 75 Director 245-34-2628 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? items 23a 1602 Samantha Court USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes. Give 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Mamied 3 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: Specify: ٥ 3 Widowed 4 Divorced Year or Dates: 'naturel', White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 4 Corporate Tax Director Tool Manufacturer if Health and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Thomas Gibson Selena Cecile Higgins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 Samantha Ct., Forest Hill 1. MD 21050 20c. Location - City or Town, State Lois F. Gibson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \*4 □Donation 5 □Other (Specify) Bel Air Memorial Grdns 2-21-04 Bel Air, Maryland Censee 21. Sign tyre of Funer (S) McComas Funeral Home, P.A. "UMas 50 W. Broadway St., Bel Air, MD 21014 23a. Part1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition Physician HYPOXIA DNE HOUR /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last ARRHYTHMIA TWO MUNTINS Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit CORDNARY METERY DISEASE NINE YEARS Due to (or as a consequence of): physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown as been signal Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No RENAL ARTENU STENOSIS 24a. Was an Jas autopsy 1 ☐ Yes 2 🗵 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 ☑ No this 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After To the Hospital or Attending 1 XNatural tnjury 5 Pending after death.

Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 
Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dire Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) RES - 000 FEBRUARY 18, 2004 MD

Registrar
DHMH 17 Rev 1/2001

State

SUSAN CHENG

31. Date fited 78 02, 794/2004

600 NORTH WOLFE STREET

BALTIMORE, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THE JOHNS HOPKINS HOSPITAL

2. Registrar's Signature

			1 - State of Registrar	Maryland / Depa	artment of He	alth and M <i>eath</i>		ene 20	04 05431
	Physic: /Medi		Decedent's Name (First, Middle, Last)     Robert	M. Green			2. Date of Death	1 <sup>Day</sup> 200	3. Time of Death 5:30 p. M
	Examir		4a. Facility Name (If not institution, give street and numb 1675 Kirkwood Road	er)	4b. City, Town, or Lo			4c. County of	f Death
	Funeral Director		5. Social Security Number 218-64-0130 6. Sex 1 AM 2 F	Age (In yrs. last birthday) 49 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Y	ear)	Birthplace (State or Foreign Country)     Md
	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f ehow ha Madical Exeminar must be notified at	ector	10a. State 10b. County  Md N/A	10c. City, Town or Lo	nore				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	eath with the 23a or 2	Funeral Director	10e. Street and Number 1675 Kirkwood Road  11. Marital Status 12. Was Decede	ant Ever in 11 S	10f. Zip Code 21207			U S A	
036	ours after de ral', or Item Exeminent	by	11. Marital Status  1 ☒ Never Married 2 ☐ Married  1 ☐ Yes 2 ☐ If Yes, Give Year or Date	es? MNo	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2🎇 No	anic Origin? (Spe Mexican, Puerto f Specify:	city Yes or No- Rican, etc.)	Black,	- American Indian, White, etc. Black
21215-0036	within 72 ho ene. than "natur he Madical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4-12)  or 5+)	dent's Usual Occupation kind of work done duri DO NOT use retired) akeman	on ing most of workin	16	b. Kind of Busi Railı	•	
Maryland 2	uld be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Clinton Green, Sr	N/A DI	18	3. Mother's Name	(First, Middle, Ma Green	iden Sumame)	)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Madical Examinat must be notified at Once.		19a. Informant's Name/Relationship (Type, Print)  Demetria Knight - Sister  20a. Method of Disposition	3114 20b. Place of Dispo	St Lukes	Library Day	lto, Md	21207	tate, Zip Code)
altimore,	permit. Pages Department of Important: If it any injury or conce.		1 ဩBurial 2 ☐ Cremation 3 ☐ Removal from State 14 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fundral Service Licensee	King Mem	natory or other place) Orial Park 2. Name and Address o	2-17-	1	andalls	stown, Md
ã	Ped Land		23a. Part1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each	sed the death. Do not ent	er the mode of dying, s	4300 W	abash Av	enue B	Approximate Interval Between
7	Physician /Medical Examiner		Immediate Cause (Final disease or condition	as a consequence of):					Onset and Death
8760,	ficate be executed physician and s the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of):					
Vital Records, P.O. Box 687	that the death certificate ed by the attending phy detached for use as the	by Physician/Medical		n 2 Fetal death 3 tat time of death 5	Ectopic pregnancy Other (specify)		- A:	23d. Date of Month	
rds, P.	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death	h but not resulting in the ur	nderlying cause given i	n Part I.	23e. Did tobac		ute to the cause of death?
al Reco	iician: The law requ certificate has been ector, page 2 shoul	Completed	Hypertension				24a. Was an autopsy performed	dea	ore autopsy findings available or to completion of cause of ath?
Division of Vita	ys diis	atlon: To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpi  27. Manner of Death 1  Natural 5 Pending 2 Accident investigation		t 3 DOA Other: 28c. Injury at Work?		(Check only one) e 5 Residence dd. Describe how i		
Divis	afte Dir	Certification:	4 Homicide building.	Injury · At home, farm, streetc. (Specify)			City or Town, S	itate)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  2 ☐ Medical Examiner: On the basis and manner  29b. Signature and title of certifier	s of examination and/or inv	e occurred at the time, ovestigation, in my opinion 29c. License nu	on, death occurred	d at the time, date	and place, and	er as stated. d due to the cause(s)  Month, Day, Year)
	y		30. Name and address of person who completed cause of	of death (Item 23a) (Type.	05/				(2,2004
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	Registr	ar	FEB 2 0 2004	Wester St. A	enter.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 8 0 L 05435 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month February Day 13, 2004 **Physician** Mary Elizabeth Ging 4:00 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Howard 9608 Glen Oaks Lane Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 30, 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2QF 173-07-5341 Pennsylvania 85 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County rthan "natural", or itams 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Greenbelt Prince George 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20770 U.S.A. 3-F Eastway Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify. White 1 ☐ Yes 2X No Completed by 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Virginia Thibodeau E. Lee Fogleman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9608 Glen Oaks Lane, Columbia, Maryland 21046 Kathleen Brock /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem Feb 18, 04 Silver Spring, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Ave. Laurel, Maryland 20707-4389 ranice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on course on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer 6 Months Physician /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: P 1 🗌 Yes 2 3 No 1 Inpatient 2 ER/Outpatient 3 DOA

**Examiner** and Il-transit the death certificate be executed physician ar s the burial-t P.O. Box 68760, as use ģ signed by the a Division of Vital Records, icate has been significate page 2 should b certificate funeral director, this After t s after dec. ral Director: After filled in by

filed within 72 hours after death with the Maryland

other

Baltimore, Maryland 21215-0036

To the Hospital or Attending within 24 hours a' completely

Certification:

Medical

31. Date filed (Month, Day, Year) State Registrar

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

resuite 000

28a. Date of Injury (Month, Day Year)

and manner stated

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

residence

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

avico 5,000

FEB & 0 2004

5 Pending

investigation

6 Could not be determined



**ORIGINAL** 

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene? 05436 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** :30 pm 2004 Francis Henry Gritz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Prince George's Lanham 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Yrs. Director 154-22-8408 81 June 18, 1922 Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes X☐ No Directo Maryland | Anne Arundel Crofton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö or Items 23a 2474 Medford Court 21114 United States Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1941–1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. permit Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "naturel", or then any injury or other traumatic event. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2🎇 No Specify: Specify: 3 ☐ Widowed 4 ▼ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Chemical Operator Dupont 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Francis Christina ၉ Koch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine M. Gritz/ Daughter 2474 Medford Court Crofton, Maryland 21114 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 2/19/2004 Odenton, Maryland 21. Sign sture of Funeral Service kie 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. Marita 9 M00957 Momoo 1411 Annapolis Road Odenton, Maryland 21113 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SOPTICEM IA **Physician** /Medical Due to (or as a consequence of): **Examiner** NEW MONIA Sequentially list conditions, Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): use as the burial-transit The law requires that the death certificate be executed DIABETTS 65 DAYS Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 UBSITUC TION 1 Yes 2 1 Ho 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 16 has autopsy performed certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1 🗓 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DH1240 MIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20916 SMITH ORMAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 2 0 2004

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	amine		ta. Facility Name (If not institution, given 3623 BAYONNE AVE				ORE CITY		4c. County of [	Death
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Fund			218-67-0666	□M 2 <b>/</b> 20 F		rs. Months Days	Hours Min.	Month, Day,	2003 B	SALTIMORE, MIX
ט		-	Usual Residence of Decedent							And Inside City City
anylan	曹	_	10a. State 10b. County		10c. City, Town					10d. Inside City Limits 12 Yes 2 □ No
Ne Mi	attio	ecto	MD		BAI	TIMORE 101. Zip Code		11	Og. Citizen of Wha	
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Jeath ns 23	TI ME	era	3023 Bayoni  11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of h	Hispanic Origin? (Spe	ecify Yes or No-		American Indian,
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Plygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-f show	Staroliner	by Funeral Director	Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2  Il Yes, Give Year or Dates:	No	1 ☐ Yes 2 No	an, Mexican, Puerto Specify:	Hican, etc.)		white, etc. White.
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or Health	othe	1	20a. Method of Disposition		20b. Place of cemeter	Disposition (Name of crematory or other pla	ce)	Date	20c. Location - Cit	y or Town, State
Page Page	ıry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci.		FVANUS FE	BECAGRIPH WERALCHAR	EL- 2-11	7-04	FOREST 1	HILL MD
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f 6			23a. Part1, Enter the disease, or comshock, or heart failure. List only	one cause on each li	the death. Do n	ot enter the mode of dyi	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
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Box 6 death certification of attending	for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnanc	:y		23d. Date o Month	
the de	peq	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death	5 Other (specify)				
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State of Maryland / Department of Health and Mental Hygiene 2004 05438

		Certificate of Death Reg. No.	4 3 0
	Physician /Medical		Death
1	Examiner	to rest Haven Nursing Center Catonsville Baltinore	
	Funeral Director	5. Social Security Number  6. Sex 12/12-38-4509  7. Age (Im Trs. last birthdey) 6. Sex 10/12-138-4509  7. Age (Im Trs. last birthdey) 6. Sex 10/12-138-4509  9. Birthplace (State or Bounty) 10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  10/12-138-4509  1	,
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~	the Hospital in 24 hours the Funeral Indicated filled	29a. Certifier (Check only one)  29a. Certifier (Check only one)  10 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
D	2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yeer)  02/18/2004  30 Name and address of person who completed cause of deeth (Item 23e) (Type, Print)  Yed M. A. Ri'HZ 100 North Hamman Formy Rubinthicum MD 210	_
	. 8	30 Name and address of person who completed cause of deeth (Item 23e) (Type, Print)  Sycal M. A. RiHZ 800 North Hammands Forny Rubinthicum MD 210	190
	State Registrar	the born of third was a second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second	

State of Maryland / Department of Health and Mental Hygiene 2 10 4 05439 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 14 Hamilton Mennis 2004 11:09PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Elkton Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 30 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F Months 77 May Director 217-20-2377 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Peges 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ans: If item 27 is marked other than "natural", or items 23e or 28e-1 show ury or other freumatic event, Its Mudical Examinist man be notified as ury or other freumatic event, Its Mudical Examinist man be notified as 1 Ves 2 □ No Director MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 202 Dodson Drive 21915 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 (☑ Yes. 2 □ No If Yes, Give Year or Dates: 1946-48 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) welder Ship Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sie Hamilton Dollie Pope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Yale/Daughter 36 Merry Knoll Lane, Conowingo, MD Baltimore, 2-18-04 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of the importent: if its any injury or ot once. 1 Burial 2 Cremation 3 Removal from State '4 ☐ Donation 5 ☐ Other (Specify) New Bridge Baptist Cemetery Rising Sun, MD 22. Name and Address of Facility R.T. Fourd Funeral Home, P.A. permit. 21. Signature of Funeral Service License 111 S. Queen Street, Rising Sun, MD 21911 uhard 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 days Myocardial Physician /Medical Due to (or as a consequence **Examiner** PTHEROSCLEROSIS CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, page 2 should be Cerebro Vascular Accident 2 200 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 200No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No Certification; To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funerel Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0058354 eath (Item 23a) (Type, Print) Rising Sun. Suite 31. Date filed (Month Day) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 👂 🛭 🖺 👢 05440 For State Registrar Certificate of Death 3. Time of Death
O9:44AM 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEARMAN 17 JO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🔀 F Yrs. **Director** 256-60-6123 63 Nov. 9, 1940 Georgia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ages 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hyglene.
If I flem 22 Is marked outher than "natural", or I tams 23a or 28a-1 show or other traumatic event, the Madical Example at mast less inclined an 1 ☐ Yes 2 XNo Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2105 Buell Drive 21047 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XXIIIO If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 200 No Specify ۵ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) 12 Hospital Administrator Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any inury or othar traumatic evant 2008: u/k Joe Weaver Arline u/k 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold G. Hyer - Husband 2105 Buell Drive, Fallston, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X2Cremation 3 ☐ Removal from State • 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 2-21-04 Towson, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or respiratory one cause on each line.

DANCEFATIC (ANCER 1317 Cokesbury Rd., Abingdon, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCEEATIC CANCER Physician MONTH /Medical Due to (or as a consequence of): Examiner VER METASTESES MONTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause) HEDATO REMAZ SYNONEME use as the burial-transit signed by the attending physician and I be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4□Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MELLITUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1. Natural

2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 □ Yes 2 □ No investigation Diractor 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State

30. Name and ad

31. Date filed (Mount) 22, 221

press of person who completed cause of death (Item 23a) (Type, Print) John M. Byrne,

		•	1 - For Amend Item #1	State of Maryland 7 per fn G828	d/Department of 2/20/04 tas Certificate of	Health and Me f Death	ental Hygien	e2004	05441
			1. Decedent's Name (First, Middle, Las				2. Date of Death		3. Time of Death
	Physici		FARI (	1/VDE.	TENKIN	5	FEB. i	2 2 veer 4	0540 M
	/Medio Examin		4a. Fecility Name (If not institution, give	street and number)		or Location of Death		c. County of Death	
4	Examili	er	CALLENT ME	manini Has	PITAL PRINC		1	47	ERT
			5. Social Security Number 6. Se	7. Age (In yrs. la			8. Date of Birth		
	Funeral Director			XM 2□F 7	7 Yrs. Months Day		(Month, Day, Yea	Coun	
	Director		Usual Residence of Decedent	/ 6	<b>A</b>		TUNE 25,1	431 FEN	USLY VANIA
	and		10a. State 10b. County	10c. City	, Town or Location			10	Od. Inside City Limits
	Aary	ō	MARINA CALVE	OF	1 11-	. 211			1 ☐ Yes 2 No
	the Marylan 28a-f show	ect	MARYLAND CALVE	RI	LUS	10 y			
		Director	10e. S/reet and Number		10f. Zip Code	2016	7 10g. C	itizen of What Coun	try?
	£ 23 €	Funerai	295 MARIO	OR DRIVE		2060	/	U.5 A	
		rue	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	<ol> <li>13. Was Decedent of If Yes, specify Cu</li> </ol>	Hispanic Origin? (Speciban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - America Black, White, e	
98	p 9 1		1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give	1 ☐ Yes 2 🛣 N			Specify: /2	
5-0036	72 hours after "natural", or ite	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				137	ACK
Ŋ	72 P	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Decedent's Usual Occ (Give kind of work don	e during most of working	16b.	Kind of Business/Ind	lustry
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P	al Hygie d other	Be	17. Father's Name (First, Middle, Last)	(WHENOWY)		18. Mother's Name	First, Middle, Maide	en Sumame)	
<u>a</u>	uid be Aental rked c	ည	David Jenkins			LAUR	A	MII	VOR
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other than other traumatic event, itte M		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Address (Street	et and Number or Rural	Route Number, City	or Town, State, Zip	Code)
Σ	nd 2 salth ar 27 is 27 is ir trau		MADY T. (TENK)	NS (WIFE)	295 HARI	BOR DR I	458V	MAZ	0657
ē,	s 1 a f Hez item othe		20a. Method of Disposition	20b. Pla	ace of Disposition (Name of	Da	te 2 c. l	MD - Z Location - City or Tov	wn, State
ē	9 = 5		1 Burial 2 ☐ Cremation 3 ☐ I	Hemoval from State	metery, crematory or other p	1 .			
altimore,	permit. Page Department of Important: if any injury or once.		'4 □Donation 5 □Other (Specify,		LOON PARK	02-2	1-04 2	ALTIHOR	EMA
Sal	permit. Departi Imports any inj		21, Signature of Funeral Service Licens	1/1, 20	22. Name and Add	ress of Facility BR	OWNJR	, KUNERA	AL HOME
	202 e a		nensh!	V. Walla	21401	U. FUZTON	HVE, XDI	LTO, MD.	21211
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the death.	. Do not enter the mode of dy	ring, such as cardiac or	respiratory arrest,		Approximate Interval Between
N.	Physician		Immediate Cause (Final disease or condition	1.10	VG CKINK	150			Onset and Death
4	/Medical		resulting in death)	a. Due to (or as a consequence		_010			A INOLIY
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Вох	death certifi e attending i od for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal (		cv		23d. Date of deliver	•
	dea e att	Ci	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of dea				Month [	Day Year
P.O.	by th	hys	9 🗆 Unknown	9□ Unknown			-		
	w requires that the death certific been signed by the attending p should be detached for use as	γP	Part II. Other significant conditions co	ntributing to death but not resul	lting in the underlying cause g	iven in Part I.	23e. Did tobacco	use contribute to the	cause of death?
Sp.	uire sig d b	q p					1 ☐ Yes 2	2 □ No 3 □ Proba	bly 4 🔁 Unknown
Records,	y req	Completed by					04-146	1	
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_		Ö					performed? 1 ☐ Yes 2 🔼 N	death? o 1 ☐ Yes 2	2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			26. Place of Death (	Check only one)		
<b>1</b>	Physic this ce al dire	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 25 ☐ E	R/Outpatient 3 DOA	ther: 4 - Nursing Home	5 Residence	6 ☐Other (Specify)	
οt	ding Pt n. After tt funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury We	ury at 28	d. Describe how inju	ury occurred	
<u>ō</u>	Attending r death. ector: After by the fune	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(**************************************		Yes 2 □No			
Division	Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hon	ne, farm, street, factory, office	28	f. Location (Street a	nd Number or Rural	Route Number,
Ö	afte Dire	Certification:	4   nomicide	building, etc. (Specify)			City or Town, Stat	e)	
	To the Hospital or Attending Physician: white 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Phy	sician: To the best of my know	dedge, death occurred at the	imo date and place an	d due to the squee/	s) and manner as ste	tod
	Hog 24 h Fur stely	Medical	(Check only 2 Medical Exami	iner: On the basis of examination	on and/or investigation, in my	opinion, death occurred	at the time, date an	id place, and due to t	the cause(s)
	# if the /	Me	29b. Signature and title of certifier	and marrier stated.	29c Licer	se number	20d D	ate signed (Month, D	lav Vaari
	F ≥ F 8 " Y	-	255. Organization and title of certifier		250. LICHT	> 0 / - ~	290. 08	ate signed (Month, D	الم الم
	01					7,4651	10	1111/20	
	0		30. Name and address of person who	ompleted cause of death (Item :	23a) (Type, Print)				
	/		DR. JUDGE	CHARLES	23a) (Type, Print) 110 Ho5P17	AL RD, Sui	EBIN ARIN	E FRENCE	KHD ZUMA
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signaru	Ire .		1/2/10		
	Registr	ar	EER 2.0 2004	Madrey St	Accept.				

**ORIGINAL** 

			1 - For State Registrar	State of Ma	aryland / [		rtment of F tificate of		and Mental H	ygier Reg. I		05442
	Physici	an	1. Decedent's Name (First, Middle, La						2. Date of Month		Day Year	3. Time of Death
5	/Medic		Howard Nor						Februa		18 2004	9:22 A M
ţ.	Examin	er	4a. Facility Name (If not institution, giracarroll County		snital		4b. City, Town, o				carroll Carroll	
	Euparal				(In yrs. last bir	rthday)	If Under 1 Year		r 24 Hrs. 8. Date of I Min. (Month,	Birth		
	Funeral Director			XXM 2□F	00	Yrs.	Months Days	Hours				rthplace (State or Foreign country) .ryland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loc	ation					10d. Inside City Limits
	a Mary	ctor	Maryland Carro	11	Wes	stmi	nster					1 ☐ Yes 2,☐No
	or 28	Direc	10e. Street and Number				10f. Zip Code				Citizen of What C	,
	eath w	erai	738 Mulligan La	ne 12. Was Decedent B	Ever in II S	12 VA	2115		rigin? (Specify Yes or		nited St	
2-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In Importment if them 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Modical Examiner must be notilised at ORDE.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Tayes 2 N If Yes, Give Year or Dates:		11	Yes, specify Cubi	an, Mexica Specify	an, Puerto Rican, etc.)	10"	Black, Whi	ite, etc.
n n	72 ho 'natur	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a.	. Deced	ent's Usual Occup kind of work done OO NOT use retired	ation during mo	st of working	16b.	Kind of Business	s/Industry
7	within ene. then	mp	Elementary/Secondary (0-12)	College (1-4or 5	+)		noruse retired mbly Wor				General	Motors
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ylalla	uld be Mental rrked rilc ev	To Be	Henry Kuhn					Ne:	llie Goss			
Mar	ind 2 sho alth and 1 27 is me or traume		19a. Informant's Name/Relationship John M. Kuhn – S				g Address ( <i>Street</i> Ominique		ber or Rural Route Num rt Sykesvi			Zip Code) nd 21784
e G	of Her of Her fitem r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [	Removal from State	20b. Place of cemeter	f Dispos	ition (Name of atory or other plac	ce)	Date	20c.	Location - City or	Town, State
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Da	permit Depart Import eny in		21. Signature of Funeral Service Lice			Ga   72	Name and Addre ry L. Ka 50 Washi	ufman ngton	n Funeral H n Blvd. El	Iome krid	At MMP. dge, Mar	, Inc. yland 21075
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0000	icate be executed physician and sthe burial-transit	dicai Ex	resulting in death) Last	Due to (or as a	consequence	of):						
O. DOX 0	The Taw requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. il yes, outcome d 1 Live birth : 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy Other <i>(specify)</i>	1			23d. Date of de Month	livery Day Year
Ĺ	as that gned b	by Pt	Part II. Other significant conditions	contributing to death bu	t not resulting in	n the un	derlying cause giv	en in Part	I. 23e. Did	tobacco	use contribute to	o the cause of death?
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N 1	siciar certif irector	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatier	nt 2□ER/Ou	dentions	3D DOA Oth		e of Death (Check only		5 TO:1	
5 7	g rhys er this eral di	<b>!-</b>	27. Manner of Death	28a. Date of Injury (Month, Day)	y. 28b. 1	Time of	3□ DOA 28c. Injun Worl	4014	ursing Home 5 Re 28d. Describe			icity)
NISION :	eath. or: After he funer	atio	1 Natural 5 Pending 2 Accident investigation	n	7 6217	nįury		Yes 2 □	]No			
	after da Direct	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		ry - At home, fa . (Specify)	ırm, stre	et, lactory, office		28f. Location City or T			ural Route Number,
	I of the tropstaled of Attanding Prysician: The lat within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of and manner stat	examination and	e, death d/or inve	occurred at the tinestigation, in my o	ne, date a pinion, de	nd place, and due to the ath occurred at the time	e cause( e, date a	s) and manner as nd place, and due	s stated. e to the cause(s)
	Within To II	Σ	29b. Signature and title of certifier	111/1 A	20		29c. License	e number	i I	29d. C	ate signed (Mont	h, Day, Year)
	\0		30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type D	l D3	3/8	4	1-61	soun 1	8,2004
	W		Jonathan	Kushner		114	Businis	5 Q	Ar Drive	2	13ths town	n, M0
	Sta Registr		31. Date filed (Month, Day, Year) FEB 2 0 20		r's Signature							
DHM	H 17 Rev 1/20	001		04 1	No 1	The state of	(I)					-
					ORI	GINA	L					

				1 - State RegistrarAMEND ITEM	State of M	arylar	nd / Depa	artment of H	Health and M	lental Hygi	ene 200	4 05443
		N		1. Decedent's Name (First, Middle,		K TINI	r Gostze	triicate oi	Death	2. Date of Death	J. No.	3. Time of Death
	Ų,	Physici /Medio		NATHAN HENF	RY KAMBA	<u> </u>	JR.			February		6:40 P M
		Examir	er	4a. Facility Name (If not institution,					or Location of Death		4c. County of De	eth
				Upper Chesapeak 5. Social Security Number			er . last birthday)	Bel 7		8 Date of Birth	Harfo	
		Funeral Director		215-28-0279	MXM 2□F		72 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1		irthplace (State or Foreign Country)
	1			Usual Residence of Decedent		.,				Aug. 7,	1931   Ma	eryland
		within 72 hours after death with the Maryland ene. then "natural", or itams 23s or 28s-f show to M. Jigal Exa ulter in ust be ricitlised at	ō	MARYLAND HAR Pennsylvania Yc	FORD <del>x</del> k	10c. C	ity, Town or Lo					10d. tnside City Limits 1 ☐ Yes 2X No
		288	Director	10e. Street and Number		1		10f. Zip Code	BEL A		g. Citizen of What 0	Country?
3		h with		522 1 <del>9303 Barrens P</del>	THOMAS RUN	ROA.	D	-	<del>17363-</del> 2101	15	110	77
00		ier deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	J.S. 13.		Hispanic Origin? (Spe Jan, Mexican, Puerto			nencan Indian,
	9	after dea or itams		1 Never Married 2 Marrie				1 □ Yes 200No		nican, etc.)	Black, Wh	iite, etc.
	003	ural',	d by	3 ☐ Widowed ► Divorced	Year or Dates:						Specify:	White
	215-0036	natu	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occup kind of work done	during most of works	ng 16	6b. Kind of Busines	s/Industry
	212	yene. r than	E G	Etementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retire			Tor range on one	
		Hygir Hygir thar		17. Father's Name (First, Middle, L.	ast)		FLITT	secter/1	Type Sette		Newspaper	
34	an	P d al	o Be	Nathan Henr		m	Cr				•	
10	aryland	E B B G	ပ္	19a. Informant's Name/Relationshi		LILIP	Sr.	na Address (Street	Margaret			Bateman Zin Codel
5	S	d 2 h a 7 ls		Marcia E. Rhode		r			Road Sout			
K	ē,	一工事表		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of natory or other plan			c. Location - City o	
1.0	more,	0 0		1 ☑ Burial 2 ☐ Cremation 3 • 4 ☐ Donation 5 ☐ Other (Spe				Cemetery	- 1	/04	Daltimos	Land Manager
	Balti	그 본 본 중 .		21. Signature of Funeral Sanfice Li		1			ess of Facility MC	Comas Fu	Daral Hom	e, Maryland
	ä	Depa Impo any i		Wille IVIUD	mas fr	X	50	West Br	coadway, B	el Air. 1	MD 21014	
		a st	7	23a. Part1. Enter the disease, or c shock, or hear failure. List of		d the dea						Approximate
	The same	Physician		tmmediate Cause (Final	A C	10	Page	Lustan	C -1			Interval Between Onset and Death
		/Medical	1	disease or condition resulting in death)	Due to (or as	a consec	quence of)	Tratory	Failure			weeks
	4	Examiner		One and the first and divine	Assi	rati	on Pu	leumon	ia.			months
		T =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consec	quence of):		. 0			
2		te be executed ysicien and e burial-transit	Examiner	that initiated events	c. Conq	esti	7	carl fa	ulune			months
9	760,	e exe		resulting in death) Last	Due to (or es		quence of):	1.1				
7º	876		lical		d. Pare	rly	sis i	+giras	ns		<del></del>	years
2	89 x	leath certificate t attending physic I for use as the t	Me	tF FEMALE:		- ()-		<u> </u>				J
(	Bo,	ath c	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	aldeath 3	Ectopic pregnancy	y		23d. Date of de Month	Day Year
3	Ö	the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of c	death 5∟	Other (specify) _				,
ambarr	۵.	de de	by Physician/Medi	Part II. Other significant condition	s contributing to death b	ut not res	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did tobac	cco use contribute t	o the cause of death?
Z	ds,	uires sign						, ,				robably 4 Unknown
70	Vital Record	v requir been s should	Completed							24a. Was an	Oth Wass	
	Re	The lav	mp							autopsy	prior to	utopsy findings available completion of cause of
	ā	ician: Th certificate ector, pag		25. Was case referred to medical						performe	No 1 ☐ Ye	s 2 No
	N.	ysician: is certific director,	To Be	examiner?	Hospitat:	ant 2	ER/Outpatien	20 DOA Oth	26. Place of Death		2 000 10	
5	of	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Inju	iry	28b. Time of	28c. Injur		8d. Describe how	e 6 Other (Spe	ecity)
2199	Division	nding I ath. r: After e funer	Certification:	1 Natural 5 Pending 2 Accident investiga		y Yeer)	Injury		k? Yes 2 □No			
ch	Vis	l or Attendi after death. Director: A	100	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At h	ome, farm, str	et, factory, office	2	81. Location (Street	et and Number or A	ural Route Number,
5		tal or A s after el Direc ed in by	Cert	3.4	building, et	c. (Opecii	(y)			City or Town, S	state)	
#	V	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director, it		(Check only 2 Medical Ex	Physician: To the best xaminer: On the basis of	t examina	owledge, death	occurred at the tin	ne, date and place, a	and due to the caus	se(s) and manner a	s stated.
F	K	the the mplet	Medical	51.07	and manner sta	ated.						
		To To	-	29b. Signature and title of certifier	) ()	_		29c. License	e number	290.	Date signed (Mon.	m, vey, Year)
		\		alliers S	· Jun.	Mr)		D	00181	17 te	bruary	11,2004
		V		30. Name and address of person w	ho completed cause of d	leath (Iter	n 23a) (Type,	HADEA	RD ROAD	Suido	105 611	210/5×
		Sta	te	31. Date filed (Manh Qay, Gear)	2004 32 Registr	ar's Signa	atylice A	BARRE DI	NU NUND	JULIYE	100/1011.	51011,112
	100	Pagietr		1 5 D N U	LUUT RECE	Street de	A Part	Section 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 8 per fh 845 7-15-05 yt
State of Maryland Department of Health and Mental Hygiene 2004 05444 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 11:22 P February 18, 2004 Jean Long /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6714 Hudson St. Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) April 28, 1924 Maryland 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 XF 79 213-14-3325 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f ahow Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mantal Hygene.

and the Hallh and Mantal Hygene.

and the Argene 23a or 28a-1 ahove and the transpace of the Argene 23a or 28a-1 ahove the receive or other transpace award, the Mantal Examples is an be reclifted at 1 ☐ Yes 2 ☐ No Director Maryland | Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 610 Umbra Street 21224 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🏋 No White If Yes, Give Year or Dates: Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Law 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pipina Loomis George Lambros 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 Tolna St., Balto., Md. 21224 Hope Long / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department o Important: If any injury or 2-23-04 OakLawn Cemetery Baltimore, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd., Baltimore, Md. 21222
23a. Port. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) laryngeal **Physician** cancer 6 wh /Medical Due to (or as a consequence of): Examiner 1045 Sequentially list conditions, if any, leading to immediate cause. Enter Unconjung Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) should be detached 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, pertension 1 X Yes 2 No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No page 2 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother Spesify 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of To the Hospital or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral D Propertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2/20/2004 MO 30. Name and address of person who compreted cause of death (Item 23a) (Type, Print) BACTMORE, MARYLAND 21224 2809 BUST BUS 9010 STREET MAKNUEL 31. Date filed (Mohri, Dy, Year) 2004 State Registrar

		1 - For Amend Item # Registrar  1. Decedent's Name (First, Midd				Cel	uncan	e OI L	Jealli	2. Date of Dea	ath		4 0544 3. Time of Death
Physic		Joyce Roa		Lauba	ch					Februa:	Day 1757 1	y Year 1, 2004	10:55 A
/Medi Examii		4a. Facility Name (If not institution					4b. City,	Town, or	Location of Death			County of Dea	
	#	2911 Creswell	1 Road	d			Bel	Air				Harfor	
uneral		5. Social Security Number	6. Sex	2 🛛 F	Age (In yrs.	last birthday)	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h y, Year)		thplace (State or Foreignuntry)
irector		215-30-9643	1018	2131	70	Yrs.				Oct. 18	8, 1	933 G€	eorgia
ž ==		Usual Residence of Decedent  10a. State 10b. County	,		10c. Ci	ty, Town or Lo	cation				·		10d. Inside City Limi
de la la la la la la la la la la la la la	ō	Maryland Harfo	ord		E	Bel Air							1 ☐ Yes 2 🔀 N
na rygiene. ed other than "natural", or items 23e or 28e-f show event, the Moulcal Expurimer rount he notified at	Director	10e. Street and Number					10f. Zip	Code			10g. Cit	izen of What Co	ountry?
238 o		2911 Creswe	ll Roa	he			2	21015	i			USA	
S E	Funerai	11. Marital Status	12.	Was Deced Armed Force	ent Ever in U	J.S. 13.	Was Deced	dent of His	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No-	-	14. Race - Ame Black, Whi	
o t	/ Fu	1 Never Married 2 Ma	rried	1 Yes 2	No No	1	1 Yes		Specify:			Specify:	
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than a	Completed	Elementary/Secondary (0-12)		College (1-4	or 5+)		etary				Hom	e Const	ruction
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arked o	To Be	Jack (nmn) O	rongh	,					Irene	(nmn)	Ola	esby	
BEE	12 0	19a. Informant's Name/Relation			sband	19b. Mailin	ng Address	(Street a	and Number or Ru	<del></del>	_		Zip Code)
127		Frederick C.	Lauba	ach. S	r	2911	Cres	well	Road, B	el Air,	MD	21015	
item other		20a. Method of Disposition		•	20b. I	Place of Dispo cemetery, crea	sition (Nan	ne of		Date	20c. Lo	ocation - City or	Town, State
int: H		1 ⊠Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (		iovai irom Si	Mt	. Zion	U.M.	Cem	etery 2-	14-04	Bel	Air, M	aryland
Department of nea Important: if item any injury or otha once.		21. Signature of Funeral Service	Licensee		1	I <del>%</del> i	cComa	Addres	neral Ho	me, P.A.		200	- 1-1/1/L
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Aedical aminer		resulting in death)		Due to (o	as a conse	guence of):	1		/	1.	ВО	NES	/ 2
		Sequentially list conditions.	b	Due to (o	ctart ras a consex	outer of):		inc	N AN	COLO 1	******		unin
sit	ulue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	Dec	+ 1	+ /	1		h 13	CANCER OF	LUNG	S	unsperne
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g phy as the	edic							0					
attending phys	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c.	. If yes, outco	ome of pregn		∃Ectopic pr	roonancy				23d. Date of de	,
e atte	Icla	in the past 12 months? 1 □ Yes 2 No			nt at time of		Other (sp					Month	Day Year
by th	hys	9 Unknown	1					_			_		
signed by the a	by F	Part II Other significant condit				sulting in the u	inderlying c	ause give	en in Part I.				o the cause of death?
S D	ted	Chimic Ob	seco	enu	ning	vic.	- Cons			101	Yes 2	<b>∑</b> No 3□P	robably 4 Unkno
900	Completed by									24a. Was autop	OSV	prior to	utopsy findings availa completion of cause
as been si	No.									perfo 1☐ Yes	rmed?	death? 1 ☐ Yes	s 2 No
ate has beer page 2 shou	Be (	25. Was case referred to medic examiner?								th (Check only o	ne)		
artificate has beer ctor, page 2 shou	ုင	1 ☐ Yes 2 ☐ VNo				ER/Outpatie			4   Nursing H	ome 5 Resid			ecify)
his certificate has beer Il director, page 2 shou		27. Manner of Death 1 ☑ Hatural 5 ☐ Pend	ding	28a. Date of (Month	Day Year)	28b. Time of Injury	M 2	28c. Injury Work	/ at ⟨? Yes 2 □ No	28d. Describe I	now inju	ry occurred	
lter this certificate has neral director, page 2		2 Accident inves	tigation d not be	On Place	f loiun. At h	nome form at			162 2 140	28f Location (	Stroot ar	nd Number or P	Rural Route Number,
n. Atter this certificate has funeral director, page 2		3 Suicide 6 □ Could	mined		g, etc. (Spec	nome, farm, st hify)	reet, tactor	у, опісв		City or Tox			arar nodie ivalliber,
n. Atter this certificate has funeral director, page 2			- 1						an data and place	and due to the	cause/s	) and manner a	
n. Atter this certificate has funeral director, page 2	Certification:	4 Homicide deter		r: On the bas	sis of examin	iowledge, deal lation and/or in			pinion, death occu				
n. Atter this certificate has funeral director, page 2		4 Homicide deter	al Examine		sis of examin		ivestigation	o, in my op c. License	oinion, death occu	rred at the time,	date and	d place, and du	e to the cause(s)
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	_	For State Registrar	State of Maryla	na / Depa <i>Cer</i>	tificate of	Death	R	leg. No.	
hysici /Medic	an al	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give s	long and sumber		4h City Town	or Location of Deatl	2. Date of Dea Month	Day Year	
xamin ineral rector	C1	University of Ma 5. Social Security Number 6. Sex	ryland Medic	al Cente s. last birthday) Yrs.	10	move If Under 24 Hrs.		y Year) 9. Bir	thplace (State or Foreign ountry) T VIRGINIA
ing at	tor	10a. State 10b. County WW BERKELEY		City, Town or Lo					10d. Inside City Limits 1 X Yes 2 No
23a or 28a at by not	Funeral Director	10e. Street and Number 434 VIRGINIA AVENUE			10f. Zip Code 254	401	1	10g. Citizen of What C USA	ountry?
al', or items ? Examinat rou	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Opivorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cut I Yes 2 No	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify:	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Examinat intral by notified at once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire LER/PACKI	during most of wor ad)	rking	16b. Kind of Business	Andustry
irked otha	To Be C	17. Father's Name (First, Middle, Last) HARRY MASON, JR.					ne (First, Middle, HORNER	Maiden Sumame)	
127 is me er traume		19a, Informant's Name/Relationship (Ty MICHAEL LONG/SON	pe, Print)			VE., MARTIN		r, City or Town, State, 25401	Zip Code)
Important: If item 2 eny injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ROSEDALE (	EMETERY	14,	2004	20c. Location - City or MARTINSBUR	
eny inj		21. Signature of Funeral Service License	Bieww	22 E	Name and Addr BROWN FUNE	ess of Facility RAL HOME, P	.O. BOX 82	1 327 W. KI RTINSBURG, W	G ST. 25402
og physician and as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):		rch or		951,	Approximate Inleval Between Onset and Death 20
the attendir	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnand Other (specify)	су		23d. Date of de Month	olivery Day Year
s been signed by should be detac	by	Part II. Other significant conditions cor	ntributing to death but not re	esulting in the u	nderlying cause g	iven in Part I.		bacco use contribute t	o the cause of death?
page 2	Completed						24a. Was a autop perfor 102 Yes	sy prior to	ulopsy findings available completion of cause of
Arter this funeral di	tion; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1. Natural 5 Pending investigation	1 Thpalient 2 28a. Date of Injury (Month, Day Yeer)	ER/Outpatien 28b. Time of Injury	28c. Inju	ther: 4 🗆 Nursing H		ence 6 Other (Spe ow injury occurred	ecify)
To the Funeral Diractor: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At building, etc. (Special Control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the c		eet, factory, office	)	28f. Location (S City or Tow	treet and Number or R n, State)	lural Route Number,
fille	edical (		sicien: To the best of my k ner: On the basis of exami and manner stated.						
ne Fu	-	29b. Signature and title of certifier			29c. Licer	ise number	2	29d. Date signed (Mon	th, Day, Year)
To the Funeral Diractor: completely filled in by the	Σ			MY	1916	50/	F	Ebruary 1	12004

Baltimore, Maryland 21215-0036

Box 68760.

of Vital Records, P.O.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 05447 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 16, 2004 7:49 A RAYMOND LOWE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL CO Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** XX<sup>M</sup> 2□ F Days Hours 212-36-9446 63 Yrs. MD Director MAR 17, 1940 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-f show the Medical Exercities must be notified at 1 ☐ Yes 2 ☐ No Directo ANNE ARUNDEL ANNAPOLIS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or itema 23a or 1300 McKINLEY STREET 21403 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Tyes 2 No 1959-If Yes, Give Year or Dates: 62 filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White þ 3 ☐ Widowed 4 ▼ Divorced "natural" Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within in and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) AUTO MECHANIC AUTOMOTIVE 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CAROLINE FRITSCHE . Pages 1 and 2 should be treent of Health and Menta tent: If itsm 27 is marked EDWARD LOWE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. ANN C. LOWE / FRIEND 4932 AVOCA AVENUE ELLICOTT CITY, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition FEB 20 1 Durial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. BALTIMORE, MD PARKWOOD CEMETERY 2004 21. Signature of uneral Service 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A. SECOND AVENUE, S.W. GLEN BURNIE, MD Part1. Enter the disease, or complication that caused the death, shock, or heart failure. List only one cause a each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events sician and resulting in death) Last Due to (or as a consequence of): Physician/Medicai the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 2□ No Yes 2□No Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Yes 2□ No Certification: To 1 ☐ Inpatient 2 x ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funaral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) OCME FEBRUARY 17, 2004 address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

2004

**ORIGINAL** 

DON KIN

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2001

			•	Cer	tificate of	Death		Reg. No.	104	U 3 4 4
		1. Decedent's Name (First, Middle, Last	)				2. Dete of De Month	eth Day	Year 3	3. Time of Death
	ysician Medical	Inez Wilma Manue	1				Februa			9:40 PM
3-	aminer	4a Fecility Name (If not institution, give					or Location of Deet			
		1832 Emily Drive			If Under 1 Year	Edgewoo			ford	
Fund Direc		220-34-0401	7. Age (In yrs. M 2 1 62	last birthday) Yrs.	Months Days		n. Jun. 2	th ly, Year) 4, 1941	9. Birthplace Country) Virgir	e (State or Foreig Nia
pu &	191 5410	Usual Residence of Decedent  10a. Stete 10b. County	10c. Cit	y, Town or Lo	cation				10d.	Inside City Limits
aryla sho	¥ 5			dgewoo						1 □ Yes 2 ☑ No
Ne No No No No No No No No No No No No No	act a	4	13	agewoo				10g. Citizen of V		
th with t	ust be notified al Director	10e. Street end Number 1832 Fmily Drive			10f. Zip Code 21	040		-	SA	
filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or theme 23e or 28e-1 show	Examiner must	11. Marital Status  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2₹ No If Yes, Give Year or Dates:	l l	Vas Decedent of I f Yes, specify Cub I ☐ Yes 2 1 No		(Specify Yes or No erto Rican, etc.)	Specify	e - American I ck, White, etc. w: Whit	
pernit. Pegas 1 end 2 should be filed within 72 hours aft Depermant of Health end Mental Hygiene. Important: if Nem 27 is marked other than "natural; or	ie i	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	lent's Usual Occup	petion during most of w	orkina	16b. Kind of Bu		•
within ene. than	r, the Medical is Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. L	DO NOT use retire	d)	•	State of		
or th	- E		2	Financ	cial Ana					sportat
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uld be Venta		Robert Earl Shupe				Anna M	Mae Morri	S		
d 2 sho thend 1 7 lame	r traumatic To	19a. Informant's Name/Relationship (Ty Russell Manuel/Hus					Rural Route Numb Jewood, M	-	State, Zip Coo	de)
Pegas 1 e	ury or other	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		sition (Name of natory or other pla m. Park	се)	Date 2-20-04	20c. Location - Watkins		
permit. Pegas 1 Depertment of h	any inju	21. Signature of Funeral Service License	Oile ands				Nome, P.A Dad, Abin		21009	
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death	n. Do not ente	er the mode of dyi	ng, such as cardi	ac or respiratory a	rrest,	Apr	proximate erval Between
Ifficate be executed  Exam  By Alexander  This is a second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second	ner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a consequence of as a consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the conse		nles	, <del>1</del>		>	2 4
lines that the death certificate be executed signed by the attending physician end	or use es the bur an/Medical	Cause (Disease or injury that initiated events resulting in death) Last	Du <i>e</i> to (or	as a consequ	uence of):					
daal	sici	Part II. Other significant conditione con	tributing to death but not resu	ulting in the un	derlying cause giv	en in Part I.	23b. Did	obacco use cor	ntribute to the	cause of death
raquiras thet tha daath	be detached for use by Physician/	Hype	Alwaro	n			1 🗆	Yes 2 No	3 Probabl	y 4□ Unknov
raqu	shoul ete							an autopsy med?	availab	autopsy findings ble prior to ation of cause th?
Tha law	Com						10	res 2 No	1 □ Ye	s 2MNo
	Be C	25. Was case referred to medical				26. Place of D	eath (Check only o	ne)		
	To Be	examiner?	lospital: 1   Inpatient 2	ER/Outpatient	3□ DOA Oth	ner: 4 Nursing	Home 5 Resid	dence 6 □Oth	er (Specity)	
£ £ 3	. ·	27. Manner of Deeth	28a. Date of Injury	28b. Time of	28c. Inju			now injury occurr		
ding I	<b>5</b> 5	1 Anaturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Yes 2 Xio				
i or Attending after death. Director: After	led in by the tunera Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (3 City or Tok	Street and Numb vn, Stete)	er or Rural Ro	oute Number,
To the Hospital within 24 hours To the Funeral	completely filled in by the tuner  Medical Certification		iclan: To the best of my knowner: On the basis of exemination manner stated.							
To th Withir To th	W W	29b. Signature and the of certifier	WO		29c. Licens	253	91	29d. Date signed	6-0	4
	4	30. Name end address of person who co	mpleted cause of death (Item  560/	230) (Type, E	aven	Blva	Ba	Hinor	e no	1239
	State	31. Date filed (Month Day Year)	37 Registrar's Signat	ture	46				<del>-</del>	•

	4	For State Registrar  1. Decedent's Name (First, Middle, Li			Cer	rtment of F	Death	2. Date of D	Reg. N		04	-
Physicia /Medica	n al	Christian Clay	Muller					Februa:	ry 1	<u> </u>	Year 004	3. Time of Death 8:30 p
Examine	r	4a. Facility Name (If not institution, gi 2233 Monocacy Ro		er)		4b. City, Town, o Essex	r Location of Deati	h	4	lc. County ( Balti		9
eral ctor			Sex 7. <b>X</b> M 2 □ F	Age (In yrs. la 82	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D June 1	rth ay, Yea 6,19	921	Cou	place (State or Foreigntry) yland
Declar		10a. State 10b. County Maryland Baltimo	re	10c. City,	Town or Loc	cation					,	10d. Inside City Limit
any injury or other traumatic event, the Medical Examiner must be notified at once.	5	10e. Street and Number	7	<u> </u>		10f. Zip Code			10g. C	itizen of W	hat Cour	ntry?
	-	2233 Monocacy Roa  11. Marital Status		ont Ever in U.S	. 13. V	2122 Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)			- Americ	can Indian,
	2	1 ☐ Never Married 22 Married 3 ☐ Widowed 4 ☐ Divorced	Year or Date	□No 5/2. s: 10/9/	45				,	Specify:		
	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		or 5+)	(Give I life. D		ation during most of wor d)	rking		Kind of Bus		
ć	e o	12 17. Father's Name <i>(First, Middle, Las</i> Christian Muller	")		Electr	ician	18. Mother's Nam Edith W					lectric
F	0 7	19a. Informant's Name/Relationship Vivian Muller (Wi					and Number or Ru Road, Ba	ral Route Numb				
		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  1 ☑ Donation 5 ☐ Other (Speci		te cen	ce of Dispos netery, crem	ition (Name of atory or other plac	e)	Date	20c. l	ocation - C	City or To	
SUCE		21. Signature of Funeral Service Lice		1202	22.	Name and Addres	ss of Eacility UZdZinski	i Funera	al H	ome.	P.A.	land 2122
an		23a: Pañ1. Enfer the disease, or conshock or heart failure. List only Immediate Cause (Final disease or condition	one cause on eacr	sed the death.	Do not ente	r the mode of dyin	g, such as cardiac	or respiratory a	rrest,	SCA,	ricit y	Approximate Interval Between Onset and Death
cal ner		resulting in death)		as a conseque		UODENUM	1					6 MOS.
	al Exalli	Sequentially list conditions, if any, leading to immediate the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the ser	c.	as a conseque as a conseque								
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Dhyelolan/Madio	iyalcıdını	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown		2 Fetal d at time of dea	eath 3 I	Ectopic pregnancy Other (specify)				23d. Date Mont		ry Day Year
3	֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Part II. Other significant conditions of Alzheimer's			ing in the und	derlying cause give	en in Part I.		obacco Yes 2			e cause of death? ably 4 Unknown
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To Be Com	2	25. Was case referred to medical examiner?	Hospital:			3 DOA Othe	26. Place of Deat	th (Check only o	пе)			
<u>.</u>	-	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of In (Month, L	itient 2 EF njury 2 Day Yeer)	8b. Time of Injury	28c. Injury Work	at at	ome 5 Resident				)
Certification:		3 Suicide 6 Could not be determined		njury - At hometric. (Specify)	e, farm, stre	et, factory, office		28f. Location (5 City or Tox	Street ar vn, State	nd Number e)	or Rural	Route Number,
Madical Cartificat		29a. Certifier (Check only one) Certifying Pr	nysician: To the bes niner: On the basis and manner	or examination	edge, death on and/or inve	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s date and	) and manr d place, an	ner as sta d due to	ated. the cause(s)
A		29b. Signature and title of certifier	0			29c. License	number		29d. Da	ite signed (	Month, D	Day, Year)
	3	30. Name and address of person who	completed cause of	death (Item 2	3a) (Type, P		7728		2	2/19/	04	
		Ba Yin Oung,	M.D.	8022 E	20121	~ D.7	Balto	7.5	2.1	236		

DHMH 17 Rev 1/2001

Sparks

State of Maryland / Department of Health and Mental Hygiene 200405450 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Matthews onstance ٧. 0920 pm 2004 02 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA Bn Himore Universityo Marylon Medico / Cente If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 ☐ XF 74 217-24-1944 Director Sept.7,1929 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or items 23e or 28e-f show the Medical Ezand artman be notified at Baltimore M.D. Woodlawn 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 U.S.A. 6807 Lenbern Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ MNo Specify: ď 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Board of College (1-4or 5+) Elementary/Secondary (0-12) Education 11th School Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any jury or other traumatic event sone. Josephine Paige John Woods 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6807 Lenbern Road, Woodlawn, M.D. 21207 Daren Matthews - Son 20b. Place of Disposition (Name of Date 20a Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 Removal from State Arbutus Mem. Park 2/21/2004 Baltimore, M.D. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Home Inc. 21. Signature of Funeral Service Licensee Julley Gwynnsfalls Pkwy Balto., M.D. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bronchesquedar **Physician** /Medical Due to (or as a consequence of): 1 month Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medlcal 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 1 Yes 2 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 TSuicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059190 2-18-04 sonne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . areenc St. BAltimore 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004

ıysici	an	1 - State Registrar  1. Decedent's Name (First, Middle, Li GORDON J. MOHR, S					2. Date of Death Month Februa	Day Yea	3. Time of Death
Medic		4a. Facility Name (If not institution, gi			4b. City, Town,	or Location of Deal		4c. County of D	
kamin	er	Franklin Square		Center		sedal		Bal	Timore
neral		5. Social Security Number 6.		(In yrs. last birthday, Yrs.	Months Days			9. 1927 M	Birthplace (State or Foreig Country) laryland
		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits
event, the Medical Examiner must be notified at	jo	Maryland Baltimo			ore Count	5y			1 ☐ Yes 2 ☐ No
	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	ral	9002 Philadelphia				1237		USA	- in the disc
	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Evaluation Armed Forces?  1 Tyes 2 No lif Yes, Give Ayear or Dates:	,	Was Decedent of If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer b Specify:	opecify Yes or No- to Rican, etc.)		merican Indian, /hite, etc. White
	Completed	15. Decedent's 6 (Specify only highest g	rade completed)  College (1-4or 5+	(Give life.		a during most of wo ad)	erking E	6b. Kind of Busine Baltimore Refuse Re	: County
		6th grade  17. Father's Name (First, Middle, Las	N/A	SeTi	-Employe		me (First, Middle, M		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To Be	George Mohr				Sophie	Weinreich	1	
		19a. Informant's Name/Relationship Betty Mohr (Wife)	(Type Print) Roberta Ann M — Wife	19b. Mail 9002	-		u <i>ral R</i> oute Nu <i>mber,</i> . Baltimor		
		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Special Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control		20b. Place of Disp cemetery, cre Gardens			Date 2	oc. Location - City	
once.		21. Topalure of Funeral Service Lice		2	2. Name and Addr	ess of Facility La	ssahn Fun ltimore,	eral Hom	e
n al er	cai Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. A C w. t & Due to (or as a Due to (or as a c.		EMIO				Onset and Death
	Medic	IF FEMALE:						4.77	
	Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify)	су		23d. Date of Month	delivery Day Year
	by	Part II. Other significant conditions	contributing to death but	t not resulting in the	underlying cause g	iven in Part I.	23e. Did toba		e to the cause of death? ] Probably 4 □Unknow
	Completed						24a. Was an autopsy perform 1 Yes 2	prior death	autopsy findings availabl to completion of cause of n? Yes 2 □ No
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100	٦.	1 Tes 2 To To 27. Manner of Death	1 Impatien		int 3 DOA	4   Nursing	Home 5 Resider		Specify)
	Certification:	1 Matural 5 Pending 2 Accident investigate 3 Suicide 6 Could not 4 Homicide determine	be an Blace of Injur	ry - At home, farm, s	M 1[	ork? ]Yes 2 □No		eet and Number o	r Rural Route Number,
	edical Cer		Physician: To the best of aminar: On the basis of a						
	edi	one)	and manner stat	ed.		nse number		d. Date signed (M	
	~		. 1		25G. LICO!	139 HUILIDE	29	G. Date Signed (M	Sill, Day, 1001/
completely filled in by the funeral director, page 2	Σ	29b. Signature and title of certified	my the		D	18487		2/17/	04

State of Maryland / Department of Health and Mental Hygiene 00 L 05452 1- Registrar #5 per fh G828 2/24 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup>6, 02:54 PM **Physician** 2004 February Matthews Theresa /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Anne Arundel Glen Burnie 502 Hamlen Road 8. Date of Birth (Month, Day, Year Dec 30, 1 Birthplece (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Days Months Hours 1 □ M 2 💢 F 40 Yrs. MD 1963 219-84-5568 Usual Residence of Decedent Director 10d. Inside City Limits with the Maryland 10b. County 10c. City. Town or Location 10a. State "natural", or items 23a or 28a-f ehow edical Examiner must be notified at 1 ☐ Yes 2 No Director Glen Burnie Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21061 502 Hamlen Road Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ht Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natureny injury or other traumatic event, Ite Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. & Elementary/Secondary (0-12) College (1-4or 5+) Howard Co. Public School School Bus Driver 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gail Matthews Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glen Burnie, MD 502 Hamlen Road Mrs. Gail Matthews / Mother 20b. Place of Disposition (Name of cometery, crematory or other place)
Glen Haven Memorial
Park 20c. Location - City or Town, State 20a. Method of Disposition Feb 20 1 XBurial 2 Cremation 3 Removal from State Glen Burnie, MD 2004 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Fineral Service Licensee 1 Second Avenue, S.W. Glen Burnie, MD 21061 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner metastate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 Yes 2X No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home Sesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes No 2 28d. escribe how injury occurred within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number CAO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) water Rd- Glec Burnit and Mayer 60 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Oaks Registrar

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			AMEND ITEM #10b&d PER F		04 JH	Certin	icate of	Death				004	0545
	Physic		1. Decedent's Name (First, Middle, Las BENJAMIN R	9	MICHAE	ELSON				2. Date of D Month	Day	Year	3. Time of Death
	/Medi Exami		4a Fecility Name (If not institution, give	street and number)				4b. City, To		ation of Dee		2004 ty of Death	1530 P
			MERCY HOSPITAL				Lladar d Van		TIMORI			/A	
	Funeral Director		5. Social Security Number 6. Se 1212-03-0004 Usuel Residence of Decedent	_M 2□F	(in yrs. last b		Under 1 Yea onths Deys		Min.	B. Date of B. (Month, D	irth ay, Year) , 1916		lace (State or Foreign try) YLAND
	ath with the Marylenc 23a or 28a-f show wat be notified at	ctor	10a. Stete 10b. County MD BALTI		10c. City, To		on TIMORE					10	0d. Inside City Limits XX Yes 2 <del>X N</del> o
	with th	Dire	10e. Street end Number 2710 – A JENNER DR				Of. Zip Code 212	Λa			10g. Citizen of USA	What Count	ry?
020	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show simportant: if item 27 is marked other than "half at Medical Examiner must be notified at ONCE.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 12 Yes 2 No If Yes, Give Year or Dates:	ver in U,S.		Decedent of es, specify Cul	Hispanic Or ban, Mexica		ify Yes or N ican, etc.)	o- 14. Ra	ce - America ack, White, e Wh	
21215-0020	n 72 ho "natur	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	166	e. Decedent	's Usual Occu I of work done NOT use retire	petion during mos	st of working	7	16b. Kind of E	Business/Ind	ustry
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aryl	2 should end Men is marke	은	NATHAN J  19a. Informant's Name/Reletionship (T)	pe, Print)	ELSON 19	b. Mailing A	ddress (Stree	FRIE		Route Numb	per, City or Town	SKOI , State, Zip (	Code)
	1 end 2 Health e em 27 is	1	MRS. JUDITH HAMA	N (DAU.)			SET HI	LL CT.	. OWI	NGS M	ILLS, M	D 211	.17
Baltimore,	Peges 1 nent of H nt: if iter		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State		ery, cremato	ry or other pla			Date	20c. Location		
altir	permit. Pege Department of Important: If any Injury or once.		4 □ Donation 5 □ Other (Specify)  21 Signature of Funeral Service Licens	0111	OHEB	22 No	M MEM.	ass of Facility		.8/04	REIST		
m	Deprime any i		8900 RELETERS TOWN	DITTO INES	VILLE,		ESVILL 21208	Ε,			SON & BI TERSTOWN		INC.
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68760	ete be hysicia the bur		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	D.	ue to (or as e	consequenc	ce of):						
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al R	The ete h page		-							10	Yes 21/10	10	Yes 2□ No
Zit.	Physician: The this certificate rel director, pa	To Be	25. Was case referred to medical examiner?	lospitel:	2 □ ER/O	utpatient 3	□ DOA Oti	her:		Check only of 5 ☐ Resi	1	or (Specify)	hospice
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Division	or Attandition deat frector: In by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place ol Injury building, etc.	v - At home, la		A 1	Yes 2□		Location (	Street and Numb wn, State)	per or Rural	Route Number,
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4	Sta	te	31. Dete filed (Month, Day, Year)	32. Registrer's	s Signature	Look	D.C.	UGIF	UM	ia.	21202	-	
, g	Registr	ar	FEB 2 0 2004	136 132	15.	Colores Colores							

			1- For State of Mary		artment of Health and rtificate of Death		ene 200	4 05451			
	Physici /Medic		Decedent's Name (First, Middle, Last)  MANYA		MALIS	2. Date of Death Month	17 2004	3. Time of Death 11:48 A M			
	Examir		4a. Facility Name (If not institution, give street and number) CHERRYWOOD MANOR NURSING HO		4b. City, Town, or Location of Dea		4c. County of Death BALTIMORE				
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In Usual Residence of Decedent	n yrs. last birthday) 73 Yrs.	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min		Day, Year) Country)				
	e Maryland a-fahow	ctor	10a. State 10b. County 10 N/A	Dc. City, Town or Lo BAL 7	ocation FIMORE			10d. Inside City Limits 1 1 Yes 2 □ No			
	ath with the 23a or 28	rai Director	3601 FORDS LA., #314		10f. Zip Code 21215	100	10g. Citizen of What Country? USA				
9036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ahow he Mudical Examiner mat be regilled at	d by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces? 1 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (stif Yes, specify Cuban, Mexican, Puel 1 ☐ Yes 2 1 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White Specify:				
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	l and 2 sho tealth and im 27 in m		19a. Informant's Name/Relationship (Type, Print)  MRS. SVETLANA MALIS (DAU.)	2 HUN		EISTERSTOW					
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8760,	icate be executed physician and s the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a co	onsequence of):							
P.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  d.  23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delin	very Day Year			
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×	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	ledicai	29a. Certifier 1 Certifying Physician: To the best of m (Check only one) 2 Medical Examiner: On the basis of examiner stated.	amination and/or inv	h occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)			
•		2	29b. Signature and title of certifier	(4)	29c. License number  1) 2 7 5 6	29d.	Date signed (Month,				
	3		30. Name and address of person who completed cause of death	(Item 23a) (Type,	1) 27569 838 Greene T	ree Ro	42	208			
F13	Sta Registr		31. Date filed (Month, Day, Year) \$2. Registrar's \$2. FEB 2 0 2004	Signature	de?						

State of Maryland / Department of Health and Mental Hygiene 2004 05455 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Dav **Physician** Stefanie Novac 7:14 PM /Medical 4a. Facility Neme (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deeth Samaritan Baltimore HOGDITA 5. Social Security Number 7. Age (In yrs. last birthday) 77 Yrs. If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2₩F 213-64-6673 Director Poland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at N/A Baltimore Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1016 Evans Way 21205 USA \*natural', or Iteme 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Thite 1 ☐ Yes 2☐XNo Specify: 3XXVidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Importent: If Iem 27 Ie marked other then "n any injury or other traumatic event, Ital Medl 2008. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul Yorosiewicz Sofia Hodak 19a. Informant's Name/Relationship (Type, Print) Paul Novac Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4400 Mary Avenue Raspeburg, Md. 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 02/24/2004 Faltimore, MD. 21224 \*4 □ Donation 5 □ Other (Specify) <sup>22. Name and Address of Facility</sup> Cvach/Rosedale Funeral 1211 Chesaco Avenue Rosedale, Naryland 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician UNKNOWN /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, I ally, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cha to for as a consequence off-The taw requires that the death certificate be executed burial-transit Exami Due to (or as a consequence of): of Vital Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death Dav Year 5 Other (specify) ate has been signed by the a page 2 should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Unknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? certificate 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 Proutpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred Division 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ò 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier mpletely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EULAND A. SE NOZ 1905601 Raven Luch BIVA Baltimore, MD 21 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FFB 2 n 2004

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	uth with the Marylar 23a or 28a-f show ust be notified at	Funeral Director	10e. Street and Num	nber				10f.	Zip Code			10g. (	Citizen of What	Countr	y?
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W	ter de items	- Line	11. Marital Status	ed 2⊡ Married	12. Was Deceden Armed Forces 1 Yes 2 5	?	5.	If Yes,	specify Cub	Hispanic Origin? (5 pan, Mexican, Puer	to Rican, etc.)	10-	14. Race - A Black, W		
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usy Baltimore	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once.		21. Signature of Fu	neral Service Lic	2						udon Pa				ne
Q			23a. Part1. Enter th	ne disease, or com	plications that cause one cause on each	ed the death	n. Do no			ens Ave., ng, such as cardia			, MD 21	A	Approximate nterval Between
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7,	physic physic the b	Physician/Medical		•	d									-	
Box 6	eath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcom			•DE					23d. Date of	delivery	
ď	death death ed for	sicia	in the past 12 1 🗆 Yes 2 🗷	months? ⊒No	1□Live birth 4□Pregnant : 9□Unknown			3 ⊟Ectopi	ic pregnanc (specify) _	у			Month	D	ay Year
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2	ading tth. : After e fune	tion	1 ☑Natural 2 ☐ Accident	5 Pending investigatio	28a. Date of In (Month, D	ay Year)		ury M		rk? ]Yes 2 ∐No			,,		
Division of Vital Becords P.O.	or Attend after death Director: ,	Certification:	3 Suicide 4 Homicide	6 Could not b determined	200. Flace UI II	njury - At ho	me, farr	n, street, fac	ctory, office		28f. Location City or T		and Number or	Rural F	Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	a Ce	29a. Certifier	1  Certifying Pt	nysician: To the bes	st of my kno	wledge,	death occur	red at the ti	me, date and place	e, and due to the	e cause	(s) and manner	as stat	ed.
	To the Hospital within 24 hours a To the Funeral i	edical	one)	2 Medical Exam	miner: On the basis and manner s	of examinat	tion and	or investigat	tion, in my	opinion, death occi	urred at the time	, date a	and place, and d	lue to th	ne cause(s)
	To t To t	Σ	29b. Signature and	title of certifier	P1	MT	)		29c. Licen:	se number	0	29d. [	Date signed (Mo	nth, Da	y, Year)
	6		30 Name and add	of of pareon who	completed cause of	death (Item	23a) /T	vna Print)	1/ 4	200		res.	rucky,	16,	2004
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State of Maryland / Department of Health and Mental Hygiene 2004 05457 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day **Physician** 4b. City, Town, or Location of Death 4c. County of Deagh /Medical Neme (If not institution, give street end number) Examiner MERCY HODY MARIS HOSPICE 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Funeral 1□ M 2□kF Hours 37 245-11-1527 Director Usuel Residence of Decedent death with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show 1 X Yes 2 □ No Funeral Director traumatic event, the Medical Examiner must be notified 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 N inton USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puento Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Peges 1 end 2 should be filed within 72 hours effer nent of Health end Mental Hygiene. Internet if Item 27 is marked other than "naturel", or ite 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☐ No Specify. Be Completed by Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) eaning 104 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 Mary Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Depertment of Health e Important: If item 27 Is any injury or other tra Mid Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State + Crematories 4 ☐ Donation 5 ☐ Other (Specify) Feb 20200 22. Name and Advisor

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mode of dying, such as cardiac or r 21. Signalure of Funeral rvice Lig Funeral Douglass - Balto, My 23a. Part1. Enter the disease, or complications that Tused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause weach line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Be Completed by Physician/Medical Examiner or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other eignificent conditione contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yee 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 463 2010 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 other (Specify) NOS NU Medical Certification: To 1 Yes 2 No this : After this funerel 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation ours efter death. 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours e To the Funerel C completely filled To the Hospital Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40854 211812004 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) St Paul Place Bultimore 21202 30000 MD 301 5,00 31. Date filed (Month, Day, Year) 32. Registrer's Signature doorker State Registrar FEB 2 0 2004

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Funeral Director		5. Social Security Number  225-12-5104  Usuel Residence of Decedent	Sex 7. Age (In yrs. la	Yrs. If Under Months	r 1 Year If Under 24 H Days Hours Mi		Year 3 9. Birt	thplace (State or Fountry)  RG-/N/
show	tor	10a. State 10b. County	J / A 10c. City,	Town or Location	BALTIMO	RE CI	TV	10d. Inside City L
or 286-	Director	10e. Street and Number	1 1 1	10f. Zi	ip Code		10g./Citizen of What Co	ountry?
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Department of Importent: If its any injury or o once.		4 □ Donation 5 □ Other (Spec	city) ME	TRO CRE 22. Name a JOS	MATORY 02 and Address preaching	BROWN	BALTIHOR JR. FUNE BALTO	RAL HO
M e attending physician and per use as the burial-transit	i Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):		anne ?	7(25/42)	
physic s the b	dicai		d					
the attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1  Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 Ectopic			23d. Date of de Month	livery Day Ye
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ ] [ ] [ ] 05459 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Pennie February 17 04 10:36a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Casey House Gaithersburg
If Under 1 Year | If Under 24 Hrs. Montogmery

9. Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min. Months Days Hours 01 65 39 West Indies <u> 212-80-0865</u> Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 XNo Germantown Montgomery 10f. Zip Code 10g. Citizen of What Country? 20874 U.S.A. 13324 Gloverdale Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Specity: Specify: 3 ☐ Widowed 4 X Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Repairman Body & Fender Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Neta Purcell Maurice Strachan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenda Gaines-Sister 13324 Gloverdale Road, Germantown Md 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 2/20/04 Randallstown 21. Signature of Funeral Service Co. March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Pert1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Encephalopathy months Due to (or as a consequence of End Stage Renal Failure months Due to (or as a consequence of). Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

February 17, 2004

**Physician** /Medical Examiner

permit. Pages 1 Department of H Importent: If ite any injury or ot once.

Examiner Physician/Medical Completed by Be ို Certification:

For State Registrar

Sylvester

5. Social Security Number

10e. Street and Number

12th grade

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

in the past 12 months?

☐Yes 2☐No

9 Unknown

1 ☐ Yes 2 X No

27. Menner of Death

1 XNatural

2 Accident

3 Suicide

29a. Certifier

29b. Signature

4 | Homicide

(Check only one)

resulting in death)

IF FEMALE

10a. State

**Physician** 

/Medical

**Examiner** 

Direct

Funeral

þ

Completed

Be 2

**Funeral** 

Director

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene. ent: If item 27 is marked other than "natural", or Itams 23a or 28a-f shov ury or other treumatic event, the Medical Exaction must be notified at

The law requires that the death certificate be executed physician and s the burial-transit P.O. Box 68760 attending physical for use as the t signed by the a Records, been page 2 certificate of Vital Hospital or Attending Physician: funeral director, this After Division s after dea. within 24 hours after de To the Funeral Directo completely filled in by Il

19

Registrar

To the

Medical

Joseph Kaplan, State

31. Date filed (Month, Bay Year) 2004

determined

of certifier

6001 Muncaster Mill Road, Rockville, Md 20855 32 Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

and manner stated



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D35635

MO

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05460 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Day Month Yeer **Physician** February Perry Mary Janet 17, 2004 5:57 p /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Laurel Regional Hospital Prince George's Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 ☐ F Yrs. 220-14-0428 80 March 2, 1923 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Laurel 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 11748 South Laurel Drive 20708 U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. and It item 27 is marked other than "natural; or the ury or other traumatic event, the Medical Esparing ury or other traumatic event, the Medical Esparing 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 20XNo Specify. White Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 1 vear Office Manager Car Dealership 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith Watson Sidney Greenfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland Edward Perry son 15 S. Broadway 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important; If Ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. Feb 20, 04 Odenton, Maryland 22. Name and Address of Facility Donaldson FuneralHome, P.A. 21. Signature of Funeral Service Licensee 84 43 / M00770 313 Talbott Avenue Laurel, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia 1 day /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi): Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p as IF FEMALE: esn. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signature Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate 1□ Yes 2√XNo the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 X X patient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury Natural 2 Accident 5 Pending investigation 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

State Registrar (Check only one)

29b. Signature and title of certifier

Syed Sadiq, M.D.

32. Registrar's Signature

31. Date liled (Month, Day, Year) FEB 2 0 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14333 Laurel Bowie Road

29c. License number

D24721

Suite 208

29d. Date signed (Month. Dav. Year)

Laurel, MD

February 18, 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Babygirl Pfeiffer 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Rosedule Square Center HOSA tal Himore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Days Min. 1 ☐ M 2 🕅 F N/A Director Md 12 Feb. 17,2004 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Director Md. Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 855 Jay Dee Ave. 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No þ Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/AN/A 0 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jason Metz Maryjo Pfeiffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason Metz father 855 Jay Dee Ave. Dundalk Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. 20, 2004 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Baltimore Bayview Crematory 21. Signature of Fundants 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk wiz 7110 Sollers Point Rd. 23a. Pa 1. Enter the disease, or complications that caused the stock, or heart failure. List only one cause on each line that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immeriate cause (Final dise se or condition resulting in death) Physician Due to (or as a of sequence /Medical Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Uncertain Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physicien Box 68760 Physician/Medical the IF FEMALE: esn. 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 M No 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 🔼 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check onlone Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 区Inpatient 2 ER/Outpatient 2 1 Tes 2 (No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification; Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number f erson who completed cause of death (Item 23a) (Type, Print) Square Drive Baltimore, G Fran Klin Registrar's Signature Year) State 0 2004 Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 2 05462 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 1:20 pM Dorothy Proud February 18, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1916 Ellinwood Road Rosedale Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Min. | Way 5, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☑ F 220-09-9828 79 Yrs. Mary Tand Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Madical Examiner rount be notified at MD Baltimore Rosedale 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1916 Ellinwood Road 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 □ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) marked other than Customer Service Baltimore Orioles 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be f h and Mental h Joseph Fonte Margaret Alascio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) . permit. Pages 1 and 2.
Department of Health ar
Important: If item 27 Is
any injury or other trau Robert D. Proud-husband 1916 Ellinwood Rd., Rosedale, MD 21237 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Gardens of Faith 2/21/04 Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 21. Signature of Funeral Service Licensee William G. Dau 5305 Harford Rd., Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ξ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f P.0. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ Division of Vital Records, 1 Yes 2 1 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 110 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation I or Attend after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral E Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 45-766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunsepr Ste. 312, Baltimore, MD 21237 MP.9105 Franklin

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

FFB 2 0 2004

32 Registrar's Signature

			State RegistrarAMEND ITEM #26 PER	ite of Maryland / Dep PHY G828 2/20/04©	partment of Health and artificate of Death	Mental Hygien	
	Physici	an	Decedent's Name (First, Middle, Last)	- 1		2. Date of Death Month Da	3. Time of Death
4	/Media		JOFFEY E. PE			Februry	16 2004 1115AM
	Examir	er	4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of Dea		County of Death
	Funeral	Verie	5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs		BALTIMORE  9. Birthplace (State or Foreign
	Director		122-34-4325 X <sup>□ M 2</sup>		Months Days Hours Min	S. 8. Date of Birth (Month, Day, Year, NOV 10, 1	9. Birthplace (State or Foreign Country) 945 NEW YORK
	land •••		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Many Fertina	tor	MD BALTIMORE	OWII	NGS MILLS		1 Tes 2 No
	th the or 28a	lred	10e. Street and Number		10f. Zip Code	10g. Ci	itizen of What Country?
	ath w	rail	12206 FAULKNER DR.		21117		USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show styl injury or other traumatic event, the Medical Evantinar must be notified at ance.	by Funeral Director	1 Never Married 2 Married 1 If Y	us Decedent Ever in U.S. ned Forces?  JYes 2 TVNo fes, Give A ar or Dates:	B. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 Mo Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) Co	nleted) 16a. Dec (Gir (Ilege (24or 5+)	cedent's Usual Occupation we kind of work done during most of wo DO NOT use retired) OWNER	orking	Sind of Business/Industry
and 2	d be filed intal Hygi ed other	To Be Co	17. Father's Name (First, Middle, Last) MICHAEL	PEPPER		me (First, Middle, Maider	
Maryland	2 should be and Mental is marked c	ĭ	19a. Informant's Name/Relationship (Type, Pri	int) 19b. Ma	iling Address (Street and Number or R	ural Route Number, City	or Town, State, Zip Code)
	and lealth m 27		RONA PEPPER (WIFE)		·····	WINGS MILLS	<u> </u>
Baltimore,	Pages 1 nent of 1- int: If ite		20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Remova		ematory`or other place)		ocation - City or Town, State
Ħ	nit. Pa artmer orfant injury		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		ORE HEBREW 2/1 22. Name and Address of Facility SC		ISTERSTOWN, MD
Ba	Departi Departi Importi sny inj		Vattoll-	with	8900 REISTERSTOWN		VILLE, MD 21208
	Physician /Medical Examiner	ner	resulting in death)  Sequentially list conditions.		nter the mode of dying, such as cardia		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	edical Examiner	that initiated events	Due to (or as a consequence of):			
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Medical	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Records, P.	w requires that s been signed b should be deta	ρ	Part II. Other significant conditions contributing	ng to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?
ဂ ဂ	aw rec is bee	Completed	HYPER CHOLEGIE	2a EMIA		24a. Was an	24b. Were autopsy findings available
Ě		mo:				autopsy performed? 1 ☐ Yes 2 ☐ No	prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
Vital	hysician: The la nis certificate ha I director, page 2	Bec	25. Was case referred to medical examiner?		26. Place of De	ath  Check only one	
	Physic this co al dire	၉	1 ☐ Yes 2 No Hospital	1 Inpatient 2XXEH/Outpati		dome esidence	6 ☐Other (Specify)
חכ	ding P	lon:	7	(Month, Day Year) 28b. Time Injury	Work?	28d. Sescribe how injur	ry occurred
Division of	or Attenditer death	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At home, farm, s building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route Number, a)
/	To the Hospital within 24 hours a To the Funeral C completely filled	edical C	(Check only 2 Medical Examiner: Or	To the best of my knowledge, dea the basis of examination and/or d manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	a, and due to the cause(s) urred at the time, date and	and manner as stated.  d place, and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		29c. License number		te signed (Month, Day, Year)
r-	2		perge	Joseph MI	> 1958933	> tel	1N29 16,2004
	10		30. Name and address of person who complete				
200	Sta	te	31. Date filed (Month, Day, Year)	5 fol out co	UPT RD RAND	tustany,	MD 21133
	Registr		EED 2 0 2004	Revenue 12 A	and I		

			1 - For State Registrar	State	of Maryla	ind / Depa	artment <i>rtificate</i>	of He	alth and eath	d Mental H	ygiene 2	004	05464	
	Physic /Medi		1. Decedent's Name (First, Middle Netter	e, Last)				Ragi	n	2. Date of E Month O2	Day 18	Year 2004	3. Time of Death 10:48a <sup>M</sup>	
	Examir		4a. Facility Name (If not institution Future Care				4b. City, T	_	cation of De	eath	4c. Cou	inty of Death		
<b>*</b>	Funeral Director		5. Social Security Number 217–26–5585	6. Sex 1 □ M <b>3.</b> F	7. Age (In yr 83	s. last birthday) Yrs.	If Under 1	Year II	f Under 24 F	8. Date of B in. (Month, 2 7-8-	irth Day, Year) 20	9. Birthpl Coun S. C	lace (State or Foreign try)	
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County  Md. NA		10c. (	City, Town or Lo						10d. Inside City		
	with the 3e or 28e-	Il Director	10e. Street and Number 2607 E. Oliver	Street			10f. Zip C	ode 21213	3		10g. Citizen	g. Citizen of What Country?  USA		
920	d within 72 hours after death with the Maryland Jone Ir than "natural", or Items 23e or 28e-f show Ire Medical Exeminer must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marr  3 Widowed 4 Divorced	12. Was Dec Armed F	2 XNo		Was Decede	nt of Hispa y Cuban, I	anic Origin?	(Specify Yes or Nerto Rican, etc.)		14. Race - American Indian, Black, White, etc.  Specify: Black		
Maryland 21215-0036	within 72 ane. than 'na	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12) 12th grade	st grade completed,	) (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use sekeep	done duri retired)	on ing most of t	working		Sinai Hospital		
land ?	be file ital Hyg id othe svent,	To Be C	17. Father's Name (First, Middle, Julia	•	McKeive				3. Mother's h Ann	lame (First, Midd)	e, Maiden Sun Bell		erry	
Mary	0, 60 99 2	<b>)</b> —	19a. Informant's Name/Relations. Annette Luster	hip (Type, Print) Daug	hter					Rural Route Num.			Code) 7 Apt. 4K	
Baltimore,	Pages 1 and 2 ent of Health nt: If itsm 27 I ry or othar tra		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  1  Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Cherry Grove Cem.  20c. Location City or Town, Stete											
Balti	permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of Funeral Service		· ·	22 N	Name and	Address o	of Facility East					
	Physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and physicien and ph	Tesulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):											Approximate Interval Between Onset and Death	
O. Box 68769	death certif e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	itcome of preg birth 2 Fe nant at time of	tal death 3	3 □Ectopic pregnancy 5 □ Other (specify)					23d. Date of delivery Month Day Year		
rds, P.O.	o o	þ	Part II. Other significant condition	ens contributing to d	leath but not re	esulting in the u	nderlying cau	se given ii	n Part I.		tobacco use c		e cause of death?	
Vital Records,	The law ate has b page 2 s	Completed					-			24a. Wa: auto perf 1 □ Yes		b. Were autop prior to com death? 1 \( \sum \text{Yes} \) 2	sy findings available pletion of cause of	
n of	Attending Physicien: The stranger.  ector: Atter this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin investig	Hospital: 1  28a. Date (Mon		□ ER/Outpatien 28b. Time of Injury		Other: Injury at Work?	4 Nursing	Home 5 Res 28d. Describe				
Division of	To tha Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu	ertification:	3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place	e of Injury - At ing, etc. (Spec	home, farm, str	eet, factory, o		Yes 2 □ No  28f. Location (Street and Number or Rural Route Numb City or Town, State)					
	a Hospita 124 hours 6 Funaral letely filler	edical C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the Examiner: On the b and man	e best of my kr basis of examination stated.	nowledge, death nation and/or inv	occurred at restigation, in	the time, o	date and pla on, death oc	ce, and due to the curred at the time	cause(s) and date and plac	manner as sta e, and due to t	ited. the cause(s)	
<b>&gt;</b>	To th withir To th comp	Me	29b. Signature and title of certifier	Sel	le mà		29c. I	icense nu	537		29d. Date sig	ned (Month, D	ay, Year) O Y	
	5		30. Name and address of person of DARSHAN S  31. Date filed (Month, Day, Year)	who completed cau	se of death (Ite	om 23a) (Type,	Print)	- Ro,	YAL P	VE BA	Etinz	2 21	217	
	Sta Registr		31. Date filed (Month, Day, Year) FFR 2	0 2004	Registrar's Sign	nature	41	J 130 A	13.A	٠,٠				

Ar	State of Maryland / Department of Health and mend Item#19aperINFG8282/27/04 EW Certificate of Death	Mental Hygiene 200	4 0546
Physician /Medical	1. Decedent's Name (First, Middle, Last) Helen M. Rieck	2. Dete of Deeth Month Dey Yee February 20, 2a	
Examiner  Funeral  Director	4e Fecility Name (If not institution, give street end number)  1. CHOSGIN RETYEMENT COMMUNITY  5. Social Security, Number  6. Sex  1 M 20 F  7. Age (In yrs. lest birthday)  Yrs.  Wonths Days Hours Min  Usuel Residence of Decedent	6,,,,,	nath  Mare Co-  irthplece (State or Foreign  Country)  1 Chigan
the Maryland 28a-f show notified at	Mayland Baltmore Co. Towson		10d. Inside City Limits 1 ☐ Yes 2 No
efter death with the Maryk efter death with the Maryk or frems 23a or 28a-f sho infrer mast be notified at 7 Funeral Director	10e. Street and Number 10f. Zip Code 21204	10g. Citizen of What C	
ours efter des ral; or items Examinar in	11. Meritel Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces 1 If Yes, specify Cuben, Mexican, Puel If Yes, Give Year or Dates:	Specify Yes or No- rto Rican, etc.)  14. Race - An Black, Wr Specify:	
Maily Idilia Z IZ I 3-UUZU d 2 should be filed within 72 hours efter death with the Marylend th end Mental Hygiene. 7 is mericed other than "natural", or items 23a or 28a-f show traumetic event, the Madical Examinar must be notified at To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16e. Decedent's Usual Occupation (Give kind of work done during most of wo	orking 16b. Kind of Busines	s/Industry
aryidand 2.1 should be filed wi nd Mental Hygien marked other thu imatic event, the	17. Fether's Name (First, Middle, Lest) William J. Maynes  18. Mother's Na  Rdit	me (First, Middle, Maiden Sumame)  Laster	/
CENL	19a. Informant's Name/Relationship (Type, Print), Daughte, 19b. Mailing Address (Street and Number of Relationship (Type, Print), Daughte, 19b. Mailing Address (Street and Number of Relationship), 2525 of Spring 20a. Method of Disposition 20b. Place of Disposition (Name of	Rd. Apr. 2430 Tim	nonium MD,
Dallimore, bemit. Peges 1 er Depertment of Hea mportant: if Item i any injury or othe once.	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  The Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Complete of the Co	2-20- 2004 Forest	Fill MD.
Dalti permit.   Depertm Importer any injur	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Plant From 2325 406K P	d. Timonium, P	remation Con MD. 21093
Physician /Medical Examiner	23a. Pagt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia speck or heart failure. List only one vause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as e consequence of):		Approximate Interval Between Onset and Death
executed in end iel-trensit	b.		()
ohysicia the bur	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last  Due to (or es a consequence of):		1
	d		 
Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribut 1 ☐ Yes 2 No 3 ☐ F	e to the cause of death?  Probably 4 Unknown
requir		24a. Was an autopsy performed?	Were eutopsy findings available prior to completion of cause of death?
ystclen: The law is certificete hes to director, pege 2 s	25. Was case referred to medical 26 Place of Dec	1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
Physicien: this certific rel director.	examiner/ 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpetient 3 DOA Other: 4 Norsing F	lome 5 Residence 6 Dother (Spe	ecify)
To the Hospital or Attending Phywithin 24 hours effect death. To the Funeral Director: After this completely filled in by the funeral Medical Certification:	27. Manner of Seeth  1 Sheturel 5 Pending investigation 3 Suicide 6 Could not be	28d. Describe how injury occurred	
To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funeral Medical Certification.	4 Homicide determined determined building, etc. (Specify)	28f. Location (Street and Number or R City or Town, State)	
the Hospit in 24 hours the Funera ipletely fill	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	e, and due to the cause(s) and manner a arred at the time, date and place, and du	s stated. e to the cause(s)
To the complete on Me	29b. Signature and title of certifier 29c. License number	29d. Date signed (Moni	
b	30. Neme and a dress of person who complete cause of deet ((Item 23e) (Type, Print)	february =	20,2005
State Registrar	31. Dete filed (Month, Day, Year)  32. Registrer's Signature	· waxer. Md &	1 20/2

		1 - State Amend Item 5 Registrar  1. Decedent's Name (First, Middle, Lie	per FH,G829,(		Cei	incai	<i>e</i> 01	Dealin		2. Date of De				3. Time of Death
Physic /Medi			Helen Lo	ouise	Ramey	7				Month Februa	ry l	, 5, 2	Year 004	6:09 A
Exami		4a. Fecility Name (If not institution, gi	ve street and number)			4b. City,	Town, o	r Location o	f Death		4c.	County	of Death	
		Manor Care Nursi	ng Home			Sil	ver	Sprin	g		Mo	ontgo	omery	7
Funeral Director		5.25c/ial Security Number 6. 212-03-5858 212-03-1915	1□M 2ÑE	9 (In yrs. Ias 88	st birthday) Yrs.	If Unde Months	Days	If Under :	Min.	8. Date of Bir (Month, De Sep 21	rth ey. <i>Yeer)</i> . 19	15	9. Birthp Coun Ohio	lace (State or Fore try)
Maryland f show	tor	Usual Residence of Decedent           10a. State         10b. County           MD         Prince	George	10c. City,	Town or Lo	cation						1	0d. tnside City Lim	
28a	Je C	10e. Street and Number	deorge	<u> </u>		10f. Zip	Code			10g. Citizen of What				try?
3a o	0	409 Montgomery S	treet			20	707				U.S.A.			
be filed within 72 hours after death with the Maryland nat Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:			Was Dece f Yes, spe			gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	p-	14. Race - American Indian, Black, White, etc. Specify: White		
2 hou	ed	15. Decedent's E	ducation		16a. Deced	ient's Usu	al Occup	ation			16b. Ki	nd of Bu	siness/Inc	
filed within 72 Hygiene. other than *na ent, the Medii	Completed	(Specify only highest given the secondary (0-12)	rade completed)  College (1-4or 5-		(Give life. L	kind of wo DD NDT u	ork done ise retired	during most d)	of workir	ng	Ur	United States Government		
should be filed and Mental Hygis marked other matic event, II	To Be C	17. Father's Name (First, Middle, Las Ralph B. Ramey	t)			18. Mother's Name (First, Middle, Maiden Sumame) Olive Rinehart								
12 sh h and 7 is m traum	-	19a. tnformant's Name/Relationship	(Type Print) /sister							Route Numb				
Heal Heal tem 2		Evelyn Wenzel  20a. Method of Disposition  1 \( \Delta \) Burial 2 \( \Delta \) Cremation 3 [		20b. Pta	ce of Dispos netery, crem					rel, Ma			City or To	
t. Partmen tant: sjury		*4 □ Donation 5 □ Other (Spec	ity)	Unio	on Cem			F ss of Facility		8, 04	Burt	onst	/ille	, MD
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Physician /Medical Examiner		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused yone cause on each lin  a. Pulmona  Due to (or as a	e. ary en	mbolis		de of dyin	ng, such as	cardiac oi	r respiratory a	rrest,			Approximate Interval Between Onset and Death
2	Examiner	Sequentially list conditions, if a.y., leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	з сопъжуче	nce (f)									
ificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a	Due to (or as a consequence of):										
death certi e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 Fetel d	eath 3	Ectopic p		′			2	3d. Date Mon	of delive	ry Day Year
signed be de	þ	Part II. Other significant conditions	contributing to death bu	ut not resulti	ing in the un	nderlying o	ause giv	en in Part I.						e cause of death? ably 4 DUnknor
The law ate has b page 2 st	Completed									24a. Was autor perfo	psy prmed?	pr		osy findings availal npletion of cause of 2 No
sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o				
d is	2	1 ☐ Yes 2 X No	Hospital:	nt 2 EF	NOutpatient	t 3□ D0	Oth Oth	er: 4 🛭 Nur	rsing Hom	ne 5 ☐ Resi	dence 6	Othe	r (Specify	)
ding h. After funer	Certification;	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Yeer) 2	8b. Time of Injury	M	28c. Injur Wor 1 🗆	yat k? Yes 2∐M		8d. Describe	how injury	occurre	d	
i Dir	Sertific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		iry - At hom :. (Specify)	e, farm, stre	et, factor	y, office		2	8f. Location ( City or To	Street and wn, State)	Numbe	r or Rural	Route Number,
To the Hospital within 24 hours a To the Funeral Completely filled	edical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best o miner: On the basis of and manner stat	examinatio	edge, death n and/or inv	occurred restigation	at the tin	ne, date and pinion, deat	d place, a h occurre	nd due to the	cause(s) date and	and man	ner as stand due to	ated. the cause(s)
To the within 2 To the complete	Me	29b. Signature and title of certifier 29c. License number								29d. Date signed (Month, Dey, Year)				

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Lalitha Tadikonda, M.D. 13952 Baltimore Avenue, Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

FEB 2 0 2004

D56797

Feb 16, 2004

DHMH 17 Rev 1/2001

Registrar

			For State Registrar		State o	f Maryla		oartmer e <i>rtifica</i> :				ental Hy	giene Reg. No		Ļ	05467
			1. Decedent's Name (F	irst, Middle, Las	it)							2. Date of De Month	eath Day	Ye		3. Time of Death
	Physici /Medic		Frances	Ε.	Sol	boda						02	18	20	104	5:15 p.M.
	Examin		4a. Facility Name (If no	t institution, give	street and nu	mber)	1	4b. City	Town, or	Location	of Death		4c.	County of C	eşih	
			Franklin	Squar	e HO				KOS	eac	le			balt		ove
	Funeral		5. Sociel Security Number 212-03-6447		ex □M 2 <b>X</b> 0F	7 Age (In yrs	s. last birthda Yrs.	y) If Unde Months	r 1 Year Days	If Under Hours	Min.	8. Date of Bir	th ay (Year)	1916	Birthpled	e (Stete or Foreign
	Director		Usuel Residence of De				115.	J			ľ	OVCIDEI		1310	i Li y i	
	and w			b. County		10c. C	ity, Town or	Location							10d	. Inside City Limits
	Many Feb	Į	MD	Bal	timore		Perry	/ Hall								1 Yes 2 No
	n the Marylan r 28a-f ehow r rotified at	Funeral Director	10e. Street and Numbe	ır				10f. Zi	Code				10g. Cit	izen of What	Country	?
	38 o	Die	1 Raylon	Drive.	Apt F				2123	36			US	SA.		
	itams 2	ner	11. Marital Status			edent Ever in	U.S. 13	3. Was Dece	dent of Hi	ispanic Or	igin? (Spec	cify Yes or No lican, etc.)		14. Race - A Black, V		
ထ္	after or its	F	1 Never Married		1 ☐ Yes If Yes, Gir	2 YNo		1 Yes		Specify:		110411, 010.7		Specify: W		**
	real',	d by	3 🕅 Widowed 4		Year or D	ates:										
oda 215-0036	n 72 h	ete	15 (Specify	. Decedent's Econly highest gra	de completed)		(Gi	cedent's Usu ve kind of wi . DO NOT i	ork done d	durina mos	t of workin	g	16b. K	nd of Busine	ss/Indu	stry
5 oda	₹ G ₽ 3	Completed	Elementary/Seconda	iry (0-12)	College (	1-4or 5+)		emaker	30 701700	/				Own hom	e	
d 2	D 0 -	Ü	17. Father's Name (Fire	st, Middle, Last)						18. Moth	er's Name	(First, Middle	, Maiden	Sumame)		
S	d 2 should be filed th and Mental Hyg 77 is marked othe traumatic event,	To Be	John W.				105 14-	Maria de deserva	/Ca-a-a	Fran		Ε.	Cuh		- T- C	- 4-1
S N N N N N N N N N N N N N N N N N N N	and 2 sh balth and 1 27 ie m er traum		19a. Informant's Name Evelyn Ban				7 R	lay <b>l</b> on	Dr.,		. J,	Baltim			2123	
ης. more.	permit. Pages 1 and 5 Department of Health Important: If Item 27 eny injury or other tr once.		20a. Method of Disposi 1 XBurial 2 C 4 Donation 5 [	remation 3		State MOS	Place of Dis	position (Na Redeem	me of other place	θ)	2/23/	04		imore,		, State
T CA	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funer			am G. Da						nard J. nore, MD			unera	1 Home
	* W		23a. Part1. Enter the	disease, or comp	plications that of	aused the dea								<u> </u>	A	pproximate
	Physician		shock, or heart fa		one cause on e	each line.	toril	fa	ilur	$\sim$					0	terval Between nset and Death
	/Medical		disease or condition resulting in death)	-	a. Due to	(or as e conse	equence of)	14	Hui	0					+	
	Examiner				Er	noh	VSEL	na								
		Jer	Sequentially list condit if any, leading to imme	diate	Due to	(or a a conse	eq ence of):									
	ite be executed ysicien and ne burial-transit	Examiner	cause. Enter Underlying Cause (Disease or inju- that initiated events		c.											
0	e exe ien ar urial-t		resulting in death) Las	1	Due to	(or as a conse	equence of):									
3760.	9 % 9	lical			d	<del></del>									-	
1 89	eath certificat attending phy	Physician/Med	IF FEMALE:													
Box	ath ce ttend or us	an/	23b. Was decedent pr in the past 12 mg			ointh 2 🗌 Fe	tal death	B □Ectopic p						23d. Date of Month	delivery Da	ay Year
C	t the dea by the a tached to	/sici	1 ☐ Yes 2 ☐ N 9 ☐ Unknown		4∐Pregr 9□Unkn	nant at time of own	death 5	5 ☐ Other (s	oecify)							
0	that the		Part IL Other significe	nt conditions o	ontributing to d	eath but not re	sulting in the	underlying	CAUSE CIVE	en in Part I		23e, Did t	obacco u	ise contribut	e to the	cause of death?
Vital Becords.	w requires that been signed be should be det	by	Dissert	ina /	forti	C An	Pilr	1.5m				ix	Yes 2	□No 3□	Probab	ly 4 Unknown
Ö	requ	etec	1)1000.	11.0				1				24a. Was		Oah Mare	autono	tindings available
e	has has	ompleted										auto		prior death	to comp	r findings available letion of cause of
<u></u>	n: The I icate ha	C										1 Yes	2 No	101	/es 2(	□No
<u> </u>	ysician: is certific director,	o Be	25. Was case referred examiner?		Hospital:		758/0		OA Othe	26		(Check only		- (70)		
alio	Phys raths	-	1 Yes 2 No			-	☐ ER/Outpat 28b. Time		28c. Injury Work	4 🗀 141		e 5 Resi			pecity)	
7 × 8	ding Ph h. After th funeral	tion		5 Pending investigation		of Injury th, Day Year)	Injury	м		<br Yes 2 □						
Division	Atten death ctor: y the	ertification;	3 Suicide	6 Could not be	e 28e. Place	of Injury - At	home, farm,	street, factor	y, office		2				Rural R	oute Number,
2	after Dire	erti	4  Homicide	00(011111100	build	ing, etc. (Spec	orfy)					City or To	wn, State	)		
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as the	edical C	29a. Certifier 1 (Check only 2 one)	Certifying Ph	ysicien: To the	best of my kreasis of examination	nowledge, de nation and/or	ath occurred	at the tim	ne, date ar pinion, dea	nd place, as ath occurre	nd due to the d at the time,	cause(s) date and	and manner place, and	as state	ed. e cause(s)
	ornple	Me	29b. Signature and title	e of certifier	1				c. License					e signed (M		
	F>F0		Caroles	y Same	- MD			R	ES	000	0		Feb.	rocky,	18,	2004
	6		30. Name and address	of person who	completed cau	se of death (Ite	em 23a) (Typ	e, Print)		^				0		
			Dr. Sano	teep S	pharn	na 9	000	Fran	Klir	150	uar	e Dr	ive	Bai	Im	2004 ore, Nd. 212
	Sta Regist		31. Date filed (Month,	Day, Year)	N's	legistrar's Sign	nature	hack		l						/

		1	For State Registrar	State of N	Marylan	d / Depa <i>Cei</i>	artment of I	Health and Death	Mental Hy	giene Reg. No	2001	05468
		_	1. Decedent's Name (First, Middle	, Last)					2. Date of D Month	eath Da	y Year	3. Time of Death
	Physicia /Medica	al	Nathaniel	W.		Scot	t		Febru		2004	11:20 AM
	Examine		4a. Facility Name (If not institution		14:	•		or Location of De		4c	. County of Deal	th
			Sinai Huspit				Boulting I Year	ore ci		1-4h	NA	halasa (Chaha as Faraina
	Funeral		5. Social Security Number	6. Sex 7 1  M 2  F	72	last birthday) Yrs.	Months Days			ax Year)	Md.	thplace (State or Foreign ountry)
	Director		218-84-0504 Usual Residence of Decedent	Λ	12						M	
4	/land	Ī	10a. State 10b. County		10c. Cit	y, Town or Lo	cation		<u>.</u> .			10d. Inside City Limits
=	Man	ğ	Md. NA			Balti	more					X□Yes 2□No
waller	72 hours after death with the Maryland *naturel; or Items 23s or 28s-f show silical Examinar must be neithed at	Funeral Director	10e. Street and Number				10f. Zip Code	215			izen of What Co USA	ountry?
	ath w	100	4010 Oswego Ct						/O // N			toon to die
ž	er des	nne	11. Marital Status	12. Was Decede Armed Force	s?	.S. 13.	Was Decedent of f Yes, specify Cub	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Ame Black, Whit	
36	rs afte	by F	1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 Tes 21 If Yes, Give Year or Date	XINO s:		1 ☐ Yes 2 <b>X</b> No	Specify:			Specify: Bl	ack
15-0036	72 hours after naturel', or ite		15. Deceden	t's Education		16a. Dece	dent's Usual Occu	pation	71	16b. K	ind of Business	Industry
215	within 72 ene. then n	pie	(Specify only highes Elementary/Secondary (0-12)	college (1-4c	or 5+)			during most of weed)	rorking			
d 212	giene giene er the	Completed	NA			Nev	er Worke				NA	
Č	三 五 表 是	Be	17. Father's Name (First, Middle,			Cookt		18. Mother's N	ame (First, Middle 1 <b>0</b> 0	e, Maiden	Jone	S
λ Ya Va		2	Nathaniel	Α.		Scott				0		
Kadwa re, Mar	12 should h and Mer 7 is marke traumatic	i	19a. Informant's Name/Relations	hip (Type, Print) Siste	~		-		Rumal Route Numi Ltimore,		21215	zip Code)
2 °	s 1 and f Health item 27 other t		Doris McCray  20a. Method of Disposition	Siste	20b. P	Place of Dispo	sition (Name of	-	Date	-	ocation - City or	Town, State
0			cemetery, crematory or other place)									el Co., Md.
Baltim	그 문학생		21. Signature of Funeral Service				Name and Addr				more, M	
1/6 Ba	permi Depa Impo eny ir once		1 must 18	11/2 Him	An		March F.	200 (EF COVID-	1101	E. N	Morth Av	
2	A DEED		23/ Pert1. Enter the disease, or	complications that cou	the death	h. Do not ent			ac or respiratory	arrest,		Approximate Interval Between
	Physician		nock, or heart failure. List	only one cause on eac		2.1.2						Onset and Death
	/Medical		discusse or condition resulting in death)	a. MASA Due to (or	as a cons							lalay
	Examiner		O WAR BUT A STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE	Preu	manie	34						8 days
XI.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Jr Janying Cause (Disease or injury		as a conseq							0 11.9
X	cuted nd transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c								
00,	ate be executed thysician and the burial-transit		resulting in death) cast	Due to (or	as a conseq	uence of):						
8760	cate b	Physician/Medical		đ					·			
9 ×	leath certific attending pi	/Me	IF FEMALE:	23c. If yes, outcor	me of pregna	incv					23d. Date of del	iven
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Feta	Ideath 3	Ectopic pregnand Other (specify)	су			Month	Day Year
P.O.	that the de led by the a	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow			(-p // -					
	res that igned b be deta		Part II. Other significant condition	ons contributing to deat	23e. Did	tobacco	use contribute to	the cause of death?				
rds	quires n sign	d by	Muscular D	ystrophy					. 10	Yes 2	□No 3□Pr	obably 4 Dunknown
0	s been sign	Completed							24a. Wa		24b. Were au	stopsy findings available completion of cause of
Re	The law te has age 2 s	шо							peri	opsy formed? 2 No	death?	2011No
ta	ysicien: The is certificate hadirector, page	0	25. Was case referred to medica					26. Place of D	eath (Check only			
Division of Vital Records,	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the buriat-transit	ToB	examiner?	Hospital: 1 1 mp		ER/Outpatier	nt 3 DOA	ther: 4 Nursing	Home 5 Res	sidence	6 □Other (Spe	cify)
0	ding Ph h. After th funeral		27. Manner of Death 1 □Natural 5 □ Pendir	28a. Date of I (Month,	njury Day Year)	28b. Time o Injury	Wi	ork?	28d. Describe	how inju	ry occurred	
sio	Attending in death.	cati	2 Accident investig	gation				]Yes 2 □ No	000	10.		18 . 1
i∑	i or Attendate after death	Certification;	4 Homicide determ	and 286. Flace of	etc. (Specif	ome, farm, sti y)	eet, factory, office	)		own, State		ural Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyir	ig Physician: To the be	est of my ken	wledge des	h occurred at the	time date and cla	ce, and due to the	e cause/s	and manner as	stated
	the Hospital nin 24 hours i the Funeral npletely filled	edical		Examiner: On the basi and manner	s of examina							
	To the Hospital within 24 hours To the Funeral completely filled	300 License number 20d Date signed (Month Day Veer)										h, Day, Year)
	- ≤ + ŏ		290. Signature and little of certifier  HBatter MD  RES-000 February 17, 2004  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Howy Bushandy MD 2401 West Belvedere Baltimore MD 21215									7,2004
	2		30. Name and address of person	who completed cause of	of death (Item	n 23a) (Type,	Print)	. ^	11.			10
	0		Houry Bashas	ndy MD	2401	West	Belve	cleve Bo	ultimor	e 1	NO 212	215
	Sta	_	31. Date filed (Month, Day, Year)		istrar's Signa							
	Registra	ar	FEB20	2004	21/2/	D	Sporks	/				

State of Maryland	/ Department of H	lealth and Menta	l Hygien <b>⊘ ()</b>	04	0;	j

469 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HEBRUARY ter field 19, 2004 veline 10:16A M /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Examiner 4b. City, Town, or Location of Death Center Towson Baltimore 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months Days | Hours | Min. | 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** 48-342 1 □ M 2 Ø F 56 Yrs. 216-Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No BALTIMOR TIMOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 212 Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2√7 No If Yes, Give Y Year or Dates: Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4or 5+) Scient 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ duar Jame lore Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Important: If itam 27 any injury or othar tra 20b. Place of Disposition (Name of Strabane DALTIMORE MD 212
Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State adremes BAUTIMORE MI \* 4 □ Donation 5 □ Other (Specify) HOL Con. 22. Name and Address of Facility BALTIMURE, MD 21234 21. Signature of Funeral Service Licensee 100 EVANS FUNERAL 23a. Part1. Enter the disease, o complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onsel and Death Immediate Cause (Final Physician RESPIRATORY FAILURE disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner UROSEPSIS S - uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner transit certificate be executed METASTATIC OVARIAN CANCER and that initiated events resulting in death) Last Due to (or as a consequence of): as the burial Box 68760, physician Physician/Medical esn. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of deliver 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the a ☐Yes 2 No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 9 LACTIC ACIDOSIS Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No RENAL FAILURE 24a. Was an has this certificate 1 Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After the Hospital or Attanding 1. Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide within 24 hours after To the Funaral Dirac 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifiei (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ini-Thichu D 31826 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ETCHARD L. LINTRICUM M.D DRIVE TENDER THAT LAND BEEN 32. Registrar's Sanature 31. Date filed (Month, Day, Year) State 2004 Registrar

	1	For State Registrar	State of Maryland	/ Depa <i>Cer</i>	rtment of H tificate of L	ealth and I Death		g. No.	. 00110
Physicia /Medic	in al	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give s		0	4b. City, Town, or	Location of Deat	te brugs	Day Year	Ø 2:10p. <sup>™</sup>
Examine Funeral Director	21 22	Milford Manor N 5. Social Security Number 6. Sex	ursing Home	st birthday) Yrs.	Pikesv If Under 1 Year Months Days			Year) (	ore rthplace (State or Foreign country) FL
land		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
Mary a-f she	tor	MD NA	Ba!	ltimo	re				XXYes 2 □ No
or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	
eath v	Funeral	2327 Koko Lane	12. Was Decedent Ever in U.S.	13. V	212 Vas Decedent of Hi Yes, specify Cuba		pecify Yes or No-	U . S . A 14. Race - Arr	erican Indian,
hours after death with the Maryland turel; or Items 23a or 28a-f show at Examiner must be notilied at	þ	1 Never Married 2 Married  3/2/3/Vidowed 4 Divorced	Armed Forces? 1 ☐ Yes <b>X</b> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Yes, specify Cuba	n, Mexican, Puerl Specify:	o Rican, etc.)	Specify:	<sub>ite, etc.</sub> B <b>lac</b> k
in 72 hor	Completed	15. Decedent's Educ (Specify only highest grade	cation o completed) College (1-4or 5+)	16a. Deced (Give life. L	ent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wo	rking	6b. Kind of Busines	s/Industry
be filed within 72 hours after death with the Marylan stal Hygiene.  Id do ther than "natural", or Itams 23a or 28a-f show event, the Madreal Examiner mast be neither at	Be Com	12th grade  17. Father's Name (First, Middle, Last)	2yrs	Te	chnicar		me (First, Middle, M		ecurity Ac
s 1 and 2 should be i Health and Mental Item 27 is marked other traumatic ev	To B	George M. Edwar 19a. Informant's Name/Relationship (Ty)		19b. Mailin	g Address (Street a	Ella I		City or Town, State,	Zip Code)
5 = 2 = 1		Sheila D. Scott-							land 21207
Pages 1 ar nent of Hea ant: If Item ury or other		20a. Method of Disposition  Burial 2 □ Cremation 3 □R  Other (Specify)	emoval from State	-	sition (Name of natory or other place Memoria			oc. Location - City of Arbutu	
permit. Pages Department of I Important: If Its any injury or o once.		21. Signature of uneral Service License	arch	M <sup>2</sup> 43	Name and Ady 19 300 Waba	i°₩ëst ish Ave	, Baltin	nore Md	21215
Cate be executed /Medical Examiner the burial-transit	dical Examiner	29a. Part1. Enter the disease, or compil shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ince of):		in so			Approximate Interval Between Onset and Death
The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 PNo 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	leath 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
uires that in signed by	by	Part II. Other significant conditions con	itributing to death but not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did tob 1 ☐ Ye		to the cause of death? Probably 4 DUnknown
	Completed						24a. Was ar autops perform 1 Yes 2	prior to ned? death	autopsy findings available completion of cause of as 2 No
Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	D/O	Oth	-0100-0-1150-	ath (Check only one	nce 6 □Other (Sp	
ine ine	tlon: To	27. Manner of Death 1 Natural 5 Pending	I _ Inpatient 2 _ E	R/Outpatier 28b. Time of Injury	28c. Injur Wor		28d. Describe ho		( <del>ө</del> сіту)
l or Attanding after death. Director: After I in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, elc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Str. City or Town		Rural Route Number,
To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 2 Medical Exami	sician: To the best of my knowl ner: On the basis of examinatio and manner stated.	ledge, deatl on and/or in	n occurred at the tirvestigation, in my o	ne, date and place pinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner ite and place, and di	as stated. ue to the cause(s)
To the compl	₩	29b. Signature and titlerof certifier	26	)	29c. Licens			ed. Date signed (Mo	*
0		30. Name and address of person who co	empleted cause of death (Item 2			004	211	sh vuer	15 200 x
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire	y Soul	٠٠٠ -		~	

			For State Registrar	State of Mary	rland / Depa Ce	artment of H	lealth and M Death		ene 200	4 05471
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic			John B	ernard	Smith, Jr		2 1		10:20 p <sup>M</sup>
may.	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	r Location of Death		4c. County of De	ath
N.			Future Care			Randa11	stown If Under 24 Hrs.	0. Date of Birth	Balto	interior (Chair as English
	Funeral		5. Social Security Number 6. Sex	7. Age (// M 2 ☐ F	n yrs. last birthday) O7 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, )		irthplace (State or Foreign Country) Md
	Director	-	212-18-5962 Usual Residence of Decedent		87 Yrs.			10-15-19	16	
	land ow	Ì	10a. State 10b. County	10	c. City, Town or L	ocation	-			10d. Inside City Limits
	Many	ξ	Md N/A		Baltimo	re				1 X Yes 2 No
	1 the	Director	10e. Street and Number		Darter	10f. Zip Code		100	g. Citizen of What (	Country?
	h with		3931 Belle Aven	ue		21215	<b>i</b>		USA	
	deat	Funeral	11. Marital Status	2. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
9	after or fte		1 Never Married 2 Married	1 XYes 2 □ No If Yes, Give		1 ☐ Yes 2 💢 No	Specify:		Specify:	Black
5-0036	72 hours after death with the Maryland natural; or items 23a or 28a-( ahow iteal Examinat must be treitified at	d by	3 XWidowed 4 □ Divorced	Year or Dates:	1					
ζ.	"natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of worki		3b. Kind of Busines	sylindustry
2121	withir ene. then	ф	Elementary/Secondary (0-12) 7th grade	College (1-4or 5+) N/A		ctor Driv			Beth1	ehem Steel
2	be filed within 72 hours after death with the Marylan ital Hyglene.  d other than "natural", or items 23s or 28s-f show event, the Medical Franchar must be codified at	ပိ	17. Father's Name (First, Middle, Last)	21,722	1124	Jeor Brav		(First, Middle, Ma	aiden Sumame)	
Maryland	2 should be filed and Mental Hygi Is marked other aumatic event, I	To Be	John B. Smith, Sr				Violet W	ashingto	n	
ary	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (Typ	e, Print)		-	and Number or Rura			Zip Code)
	1 and 2 Health a tem 27 is		Linda Smith - Da	ughter	280	7 Diamond	Ridge Ro	Called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the called to the ca		
altimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	1	20b. Place of Disp cemetery, cre	osition (Name of matory or other plac		Date 20	Oc. Location - City of	or Town, State
Ĕ	Pages nent of I ant: If Its ury or o		* 4 □ Donation 5 □ Other (Specify)	Jinovai nom otato	Garden o	f Eternal	2-20		Finksburg	
alt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	7 /	2	2. Name and Addre			F/H Wes	
_	20539		23a, Part1, Enter the disease, or complic	arch			4300		venue B	Approximate Interval Between
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<u>α</u>	uires that n signed b	by	Part II. Other significant conditions con	tributing to death but, r	not resulting in the	underlying cause giv	ven in Part I.	23e. Did toba		to the cause of death?  Probably 4   Unknown
Records,	The law requir ate has been si page 2 should	Completed						24a. Was an autopsy perform	prior to	autopsy findings available o completion of cause of
Vital		Be	25. Was case reterred to medical examiner?					h (Check only one		
ot	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	မ	1 Yes 22 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	2 ER/Outpatie  28b. Time (Injury)	of 28c. Injur	4 Nursing Ho	me 5 Residen 28d. Describe how	ce 6 Other (Sp v injury occurred	pecify)
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	he Hospit n 24 hour. he Funera	edical	29a. Certifier 12 Certifying Physics (Check only one) 2 Medical Examin	nician: To the best of ener: On the basis of eners and manner state	cantination and/or i	th occurred at the time nvestigation, in my o	me, date and place, opinion, death occur	red at the time, dat	e and place, and d	ue to the cause(s)
	To the Comp	W	29b. Signature and title of certifier	an x	to	29c. Licens	3290	7 (29	d. Date signed (Mo) $210$	OH, Day, Year)
_	UX,		30. Name and address of person the co	SUST	XULL	) Pritt) # (	04 3	alto, 1	nd. 2	1215
	St. Regist	ate rar	31. Date filed (Month, Day, Year)  FFB 2 0 200	32 Registrar's	s Signature	all is			. ,	

			For State Registrar	State of Maryland / Dep Ce	artment of Health and M rtificate of Death	Reg. N	
	hysicia /Medic		Decedent's Name (First, Middle, Las     Walter Safchi			2. Date of Death Month D Febluary	ay Year 1-10 M
	xamin	er	4a. Facility Name (If not institution, give	re Hospital	Ab. City, Town, or Location of Death Rose Con Control If Under 1 Year   If Under 24 Hrs.	1	Bo It mare
	neral ector		5. Social Security Number 6. S. 161–18–6312  Usual Residence of Decedent	7. Age (In yrs. last birthday,	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea June 3, 1	9. Birthplace (State or Foreign Country) 917 Pennsylvania
e Maryland	ta-f show	ctor	10a. State 10b. County  Maryland Baltimor	re Middle	River		10d. Inside City Limits 1 ☐ Yes 2€€No
h with th	3a or 2i at be no	al Dire	10e. Street and Number 2218 Old Eastern A	venue	10f. Zip Code 21 220		Citizen of What Country? USA
Idi yidiild KIKIIS-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	oriant: if itam 27 is marked other then "naturel", or items 23s or 28s-f shov injury or other traumatic event, the Medical Examinar rust be notified at 8.	by Funeral Directo	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ★ Yes 2 □ No If Yes, Give	Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No- b Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
within 72 hou	then "nature on Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) (Give life.	edent's Usual Occupation e kind of work done during most of won DO NOT use retired) ithographer	king	Kind of Business/Industry
should be filed or	rked other tic event, it	To Be Co	17. Father's Name (First, Middle, Last) John Safchuck			ne (First, Middle, Maide	
and 2 shows	27 Is ma r trauma		19a. Informant's Name/Relationship ( Mary Catherine Saf		ing Address (Street and Number or Ru Old Eastern Avent		
mit. Pages 1 and 2 partment of Health	Important: If itam 27 any injury or other tr once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control	Removal from State	osition (Name of smattery or other place)  Cemetery 2/20/		Location - City or Town, State timore, Maryland
permit. Pag Department	Importa eny inju once.		21. SignAury of Funeral Service Licer	// // B	2. Name and Address of Facility Pruzdzinski Funera 407 Old Eastern A	l Home P.A. venue Essex	к, ма. 21221
/Me Exa	edical edical miner	Examiner	23a Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to the least cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ion into mode on dyrig, secon as our disc	or respirately arrest,	Approximate Interval Between Onset and Death
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Or VILAI Physician: T	is certifica director,	Be (	25. Was case referred to medical examiner?			th (Check only one)	
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ding .	ctor: After th y the funeral	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	8 29a Place of Injury. At home farm of	Work? M 1 Yes 2 No	28d. Describe how in	and Number or Rural Route Number,
spital or	To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Ph	building, etc. (Specify)  ysician: To the best of my knowledge, dea	ith occurred at the time, date and place		(s) and manner as stated.
Fo the Ho within 24 l	To the Fu	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier	niner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occu		and place, and due to the cause(s)  Date signed (Month, Day, Year)
To	₽ ē		255. Signature and the or settine	am			
4	Χ'		Or. Jude munese	completed cause of death (Item 23a) (Type	Quale Drive	Baltimo	ruory 17,2004 12 MP,21237
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	DOCKE		

CPM 04-01025 NATALIE SMITH

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Item #8,10f-g,19a-b per in G828 2/26/04 tas

Amend Item #8,10f-g,19a-b per in G828 2/26/04 tas

E SMIT	п	1- For Unpend Item #23a	State of Marylan & 27 per me G82	d / Dep 2/26/	artment of H Of tas tificate of L	ealth and N Death	Mental Hyg	jiene 2 (	004	05473
		Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time of Death
Physici /Medio		Natalie Kaye G	ermain Smit	t h			Februar		2004	19:10 M
Examir		4a. Facility Name (If not institution, give st Prince George's Hos			4b. City, Town, or Chever	Location of Death		Princ	y of Death e Geo	rge's
Funeral Director		5. Social Security Number 6. Sex 1 □	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 11–25–1	Year) 962	9. Birthp Cour Jami	
permit. Pages 1 and 2 should be liked within 2 hours after beam with the maryland Department of Health and Mental Hygiene.  Department if item 27 is marked other than 'natural', or itema 23a or 28a-f ahow any injury or other traumatic avent, the Medical Examinating Invalidatial appage.	Director	Usual Residence of Decedent           10a. State         10b. County           MD         Prince G		y, Town or Lo	Heights					0d. Inside City Limits 1 □ Yes 2 □ No
or 28	Dire	10e. Street and Number			10f. Zip Code			0g. Citizen of		ntry?
23a	rai	6892 Walker Mil		6 140	20743			JAMAIC.	A ce - Americ	nan Indian
, or itams	by Funeral	11. Marital Status  1 Never Married 2 Married  3 😘 Vidowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 22 21No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 2 No	Specify:	Rican, etc.)	Bla	Blac	etc.
n /z nour n natural	Completed t	15. Decedent's Educi (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of worl	king	16b. Kind of B		
Hygiene. Hygiene. ther ther	e Comp	Elementary/Secondary (0-12)  1. Father's Name (First, Middle, Last)	college (1-4or 5+) year	Hote:	1	18. Mother's Nam		Priva Maiden Suma		
d De Antal Kad o	0 8	Harry S. Germai	n			Rose F	Hyatt G	ermai	n	
mari umati	-	19a. Informant's Name/Relationship (Typ		19b. Maitir	ng Address (Street a	and Number or Ru	ral Route Number	, City or Towr	, State, Zip	Code)
alth a		Deon Germain - son		1011	Monroe St	reet NW	Washing	ton, D	C 200	10
rages 1 a lent of He nt: If item ry or othe		20a. Method of Disposition 1	moval from State	cemetery, crei	sition (Name of matory or other place Memoria	4	Date 17day 14	20c. Location Lanha: Princ	- City or To m , Ma e Geo	own, State aryland orges
Departm Departm Imports any inju		21. Signature of Fugeral Septice Licenses		22	2. Name and Address	s of Facility La				Home h.DC20011
		23 Part1. Enter he disease, or complic shock, or hear failure. List only one Immediate Cause (Final				g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
hysician /Medical Examiner		disease or condition resulting in death)	Hemolytic Urem		come					
nsit	Examiner	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a conseq	uence of):						
icate be executed physician and s the burial-transit	dicai Exal	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):						
g phy:	40	0.								
The raw requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			1	ate of delive onth	ory Day Year
fulles that the de n signed by the a uld be detached to	by	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	<u>.</u>		ne cause of death? ably 4 \(\sumbule \text{Unknown}\)
the taw require ate has been sin page 2 should to	Completed						24a. Was a autops perform	SV .	prior to col death?	psy findings available impletion of cause of
Physician: In this certificate ral director, pag	Be (	25. Was case referred to medical examiner?			04		th (Check only on	10)		
this car	2	1 Yes 2 No		ER/Outpatier		4   Nursing ri	ome 5 Reside			y)
D 0 0	ation:	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	rat (? Yes 2 □ No	28d. Describe ho	ow injury occu	rred	
rai or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tniury - At h building, etc. (Specil	ome, farm, sti fy)	eet, factory, office		28f. Location (Si City or Town		ber or Rura	l Route Number,
To the Hospital of Attendant within 24 hours after death.  To the Funeral birector: All completely tilled in by the fur	edicai		cian: To the best of my kno er: On the basis of examina and manner stated.							
within To th	Σ	29b. Signature and title of certifier	010		29c. License	number	2	9d. Date sign	ed (Month,	Day, Year)
			npleted cause of death (Iter		Print)	C.M.E.		Februa		
-02		S. R. HOGA			Penn Str	ceet, Bal	timore,	Maryla	nd 21	201
Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 2 0 2004	32. Registrar's Signa	d jo	parks					

State of Maryland / Department of Health and Mental Hygiene 2004 054**74** Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Soukup **Physician** Stephen John 6:30 PM Febury 17 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Union Memorial Hospital | Months | Days | Hours | Min | December 26, 1921 | Distict of Columbia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₩ 2□F 82 213-14-8952 Director Usual Residence of Decedent fited within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County of Health and Mental Hygiene. Item 27 le marked other than "natural", or Items 23a or 28a-f ahow other traumatic avant, the Medical Exercitest mast be notified at Baltimore 1 X Yes 2 □ No n/a Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3632 Keystone Avenue 21211 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ★1 Yes 2 □ No WW II If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Administrator Federal Government n/a permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic and 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Adam Soukup Katherine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Susan Soukup-daughter 3632 Keystone Avenue, Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corporation 2/19/04 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Towson, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home William G. Dau 21. Signature of Funeral Service License 5305 Harford Rd., Baltimore, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Des Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -transif Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions coetributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Wasan autopsy performed? Yes 2 Ser page 2 certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ۵ 1 Tes 2 ER/Outpatient 3 DOA this 28a. Da of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After or Attanding 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funaral Dire the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of 29c. License number MXD. o completed cause of death (Item 23a) (Type, Print) ON EFFE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 2 0 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 104 05475 State Registrar Amer: d Item#8perFHG8282/24/04 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 10954 **Physician** eprom 2004 tevenson nev. aura /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** NA 7. Age (In yls. last birthday) BALTO Levindale perplace If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 3/18/1917 9. Birthplace (State or Foreign (Month, Day, Feat) 50 uth Carrollus 5. Social Security Number 6. Sex **Funeral** JB 1 M 2 A F 213-14-2524 arroling Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 Ave 5111 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 end 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Minister nd Mental Hygiene. marked other than ith and Mental Hygie 27 is marked other r traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary t ulton Watson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto Stevenson nt of Heelth a :: if item 27 is r or other tra William H. 5111 21215 Arbutus -husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Peges 1 1 Deurial 2 Cremation 3 Removal from State Courson Forest permit. Pege Department o Important: if any injury or VAcen 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Ouglass
Carton Bo 21. Signature of Funeral Service Licenses Funeral Service, P.A. Balto Jan 1701 McCulloh St 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) JAZTEK4 **Physician** oronam /Medical Que to (or as a consequence of): Examiner estive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed pertension use as the burial-tran P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ğ Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknow been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. Completed by 2000 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 (No page 2 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ٩ 1 Dipatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Avairal 2 Accident 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: After or Attending Injury Division 5 Pending 1 Yes 2 🗌 No death. investigation the Director: within 24 hours after dea To the Funerel Director completely filled in by th 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide The contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Debra

We 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OP

32. Registrar's Signature

		-	For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of H	lealth and Death		giene 2 (	304	05476
			Decedent's Name (First, Middle, Las	1)				2. Date of Dea	ath Day,	Yeer	3. Time of Death
	Physicia /Medic		ALAN			SCHAPIRO		Februar	76	204	0830AM
Sal.	Examin		4a. Facility Name (If not institution, give	street and number)		D 11.	r Location of Dea	th	1	ty of Death	
	Funeral		5. Social Security Number 6. So	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h y, Year)	9. Birthpla Count	ace (State or Foreign ry)
	Director		210-20-9700	X <sup>M 2□ F</sup> 79	Yrs.			JAN 1,	1925	MARY	LAND
	2 3	-	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10	d. Inside City Limits
	sho sho	5	MD BALTIM		BALTIN						1 ☐ Yes 2 ☐ No
	158a-1	Director	10e, Street and Number	OKE	DALIII	10f. Zip Code			10g. Citizen of	f What Count	ry?
	with a			#202		21208			LICA		
	leath	Funeral	8002 BRYNMOR CT	12, Was Decedent Ever in U.S	5.   13.	Was Decedent of H	lispanic Origin? (	Specify Yes or No-		ace - America	
<b>'</b>	fer d	표	t ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☐ No		If Yes, specify Cuba		to Rican, etc.)		ack, White, e	
9	ours after death with the Marylan rai', or items 23a or 28a-f show Examiner mast be nuitied at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:		1 □ Yes 2 🛣 No	Specify:		Speci	iry: W	HITE
20	72 hours after death with the Maryland "natural", or Items 23s or 28s-f show olical Examinar must be nutition at	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occup	ation during most of wo	rking	16b. Kind of I	Business/Ind	ustry
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Maryland 21215 <sup>1</sup> 0036	d in b	Be	17. Father's Name (First, Middle, Last) BERNARD	SCHAPIR	Λ		ROSE			KRESS	
2	d 2 should be th and Mental 27 is marked of traumatic eve	2	19a. Informant's Name/Relationship			na Address (Street					Code)
Ma	tra tra		BERNICE SCHAPIR			BRYNMOR				21208	,
ģ	Heal Heal ther		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of		Date	20c. Location		wn, State
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altimore,			21. Signature of Fune al Service Lice	560		2. Name and Addre		SOL LEVI			
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		П	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	. Do not en	er the mode of dyir	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final	no als		1 11 1	Vendicula	1 1	cata		Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ		ny Trumice (	1 Challonia	Tacqua	10(0)		
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	be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ	ance of):						
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9 X	leath certifica attending ph I for use as th	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnal	ncy				23d. D	ate of delive	rv
Box	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de		□Ectopic pregnancy □ Other (specify)	y 				Day Year
0	thet the ded by the detached	lys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown							
٩	The law requires thet the death certificate be executed to has been signed by the attending physician and orgo 2 should be detached for use as the burial-transit	by Pt	Part II. Other significant conditions of	ontributing to death but not resu	ılting in the u	inderlying cause giv	ven in Part I.	23e. Did to	obacco use co	ntribute to the	e cause of death?
Records,	quires							101	res 2□No	3 Proba	ably 4 Unknown
ပ္ပ	aw requir s been si 2 should	Completed						24a. Was autop		. Were autop	osy findings available
R	The lav	Eo		_				perfo. 1 ☐ Yes	med? 20 No	death?	
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ū	0 0 0	on:	27. Manner of Déath 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rk?	28d. Describe h	now injury occu	urred	
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Division	or Al after d Direction by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	r)	reet, ractory, onice		City or Tox		noor or more	ricolo riambor,
J	spitel ours nerai filled		29a. Certifier 1 Certifying Pt	ysician: To the best of my know	wledge, deat	h occurred at the til	me, date and place	e, and due to the	cause(s) and n	manner as sta	ated.
	To the Hospitei or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Exer	niner: On the basis of examinal and manner stated.	ion and/or in	vestigation, in my o	opinion, death occ	urred at the time,	date and place	e, and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	_		29c. Licens	se number		29d. Date sign	ned (Month, L	Dey, Year)
	1		Dimos 2 X	ne ms		KE.	5-000		Februar	4. 16,	2004
	5		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)	. / ^	, , ^		71.	4.0
_	<i>'</i>		James E. Spore, M.	O. Sinai Hospital	ot baj	prove 24	ol W, Be	wedere Hi	venue, I	Dal timore	MJ 21215
	St Regist	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture	make s					

05477 State of Maryland / Department of Health and Mental Hygiene 2 11 14 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) SIEGEL **ESTHER Physician** FEB 7:50P 16 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner N/A 2901 E. STRATHMORE AVE. BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F MARYLAND 1922 Director 213-12-6663 81 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State rai', or items 23a or 28a-f show Exeminer must be notified at BALTIMORE 1 Yes 2 No MD N/A Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21214 USA 2901 E. STRATHMORE AVE. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced "natural", er than "nature, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry nontal Hygiene.
7.27 is marked other than "traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) **FURNITURE** OFFICE CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ABRAMSON** SARAH GOL DMAN MORRIS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 I MRS. JANIS HYATT (DAU.) BALTO.,MD 21236 211 LYNDALE AVE. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: if ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) KNESSETH ISRAEL ANSHE KOLK 2/18/04 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PIKESVILLE, MD Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transil that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. attending physicien Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) Yes 2 1140 o the 9 Unknown signed by ے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ Mo Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 1 Tyes 2 No certificate 1 ☐ Yes 2 No Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; After Injury 1 Hatural 5 Pending the Hospital or Attending inin 24 hours after death.

o the Funeral Director: After the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral or the funeral 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie With 04 NWW 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Ho Kins Bendam Center 5505 JAMVEL C. DURSOMI

State Registrar

FEB 2 0 2004

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene • • •

						Cert	ificate o	f Death	ivicitai i iy	Reg. No.	0 7	05478	
DI.		1. Decedent's Nar	me (First, Middle, L	est)					2. Date of Dee	eth Day	Yeer	3. Time of Death	
Physi /Med		ELIZA	BETH JOSE	PHINE SU	CHANEK	TULACE	Χ		Februar	y 17, 2	2004	11:45 AM	
Exam			(If not institution, gi		ber)			4b. City, Town, or		,		Country	
			NDS NURSI		~ A - 4	1 -11 14 1 1	If Under 1 Ye	Sandy Sp ar If Under 24 Hrs	_	-		County	
Funera Directo		5. Social Security 213-42-2	2587	Sex 7 1□M 2□F	7. Age (In yrs.	last birthday) Yrs.	Months Day		(Month, Da	N Year) 8, 1910	9. Birthpla Counti Mary	ice (State or Foreign y) Land	
and and		Usual Residence of	10b. County		10c. Ci	ity, Town or Loca	ition				10	d. Inside City Limits	
Maryl 4 sho	ō	Maryland	Montgom	ery Co.	į	Silve	r Sprin	ng				1 ☐ Yes 2 💆 No	
1 the	<u>s</u>	10e. Street and Nu	umber				10f. Zip Code	9		10g. Citizen of	Whet Countr	y?	
h wit	<u></u>	15133	3 Middleg	ate Road			2	20905		USA	A		
Baltimore, Maryland 21215-0020 permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health end Mentel hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status	rried 2 Married	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Yeer or Date	dent Everin U ces? 2 🔯 No		as Decedent of Yes, specify Co	of Hispanic Origin? (Suban, Mexican, Puer Io <i>Specify:</i>	Specify Yes or No- to Rican, etc.)	14. Rad Bla Specif	ce - America ick, White, e fy: Whi	tc.	
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D D Ph Og Ph Iter th		27. Manner of Dea	ath 5 🗌 Pending	28a. Dete of (Month	f Injury o, <i>Day Year)</i>	28b. Time of Injury	28c. Ir		28d. Describe h	ow injury occur	rred		
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Division of Vital Re To the Hospital or Attending Physicien: The it within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)	10 Certifying P 2 Medical Exe	hysicien: To the b miner: On the bas and manne	sis of examina	owledge, death o ation end/or inve	occurred at the stigation, in m	time, date and place y opinion, death occi	e, and due to the ourred et the time,	cause(s) end madate and place,	anner es sta and due to t	ted. he cause(s)	
To the within 7	Me	29b. Signature en	d title of certifier	0.0			29c. Lice	ense number		29d. Pate signe	ed (Month, D	ay, Year)	
1		• (1_	5	HI.	-(		D	. 2534	5	2/17/	MO		
0		30. Name and add	dress of person who	completed cause	of death lite	m 23a) (Type, P	int) Joh	ME GLA	MCYIT	MD	1		
•		1731 B	K1665 (	HANE	1 Rd	SILV	25.2	PRINE	My 3	2000			
S	tate	31. Date filed (Mo	nth, Day, Year)	32. Re	gistrar's Sign	ature			,				

State of Maryland / Department of Health and Mental Hygiene 2004 05479 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Ray mond 10 Rain)
4a. Facility Name (If not institution, give street and number) 10:14 PM FURRUARY 17 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Inion Memorial Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 D 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**☑**M 2□F 213 52 5208 Director December 16,1946 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No MD Director Baltumes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 1360 U.S.A. Pentwood Completed by Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No IfYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DERVICE Spritorial 17. Father's Name (First, Migdile, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be it of Health and Mental IMPRIES 2 Wasself Pages 1 and 2 should Ornin RKU75 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) TOMIN BAltmers MD 21239 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Forest cemetry 4 □ Donation 5 □ Other (Specify) 2/25/04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BEAS TureRAI Home N CHAULINE ST BAHMING MD 2/213 Both Vaturcia Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PNEUMONIA disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of); Examiner EREBRO VASCULAR INFARCI DAYS fany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Įo. in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No or Attending Physician: the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled the Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sompta, MD FEBRUARY 17, 2004 AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FLOSPITAL 201E UNIVERSITY PARKWAY SHAILI GIUPTA, MD UNION MEMORIAL BALTIMORE MD 21218 A selection 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

	1 - State Registrar		-		Certificate of	Death	2. Date of De	Reg. No.		3. Time of Death
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Funeral Director	5. Social Security Nu 215-28-78	ımber 6. S	ex 7. Ag □M 2 <b>X</b> ☐F	e (In yrs. last birt 72	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 1,	1931	9. Birthp Cour MD	place (State or Forei ntry)
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with the Mar or 28e-f st be notified Director	10e. Street and Num				10f. Zip Code			10g. Citize	en of What Cour	ntry?
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ifter death v	11. Marital Status	v	12. Was Decedent Armed Forces?		13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14	<ol> <li>Race - Americ Black, White,</li> </ol>	
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	200. 1 dit i. Lintoi ti	ne disease of com	plications that cause	the death. Do n						Approximate
		rt failure. List only	plications that cause one cause on each l	d the death. Do r	not enter the mode of dyi	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset_and Death
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 05481 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Day -Month Year **Physician** 4,2004 irner 0 bruary /Medical 4b. City, Town, or Location of Death Ac. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Sing timore IVIanor HD Ton If Under 24 Hrs. 7. Age (In yrs) last birthday)
Yrs. 8. Date of Birth If Under 1 Year Birthplace (Stete or Foreign
Country) 6. Sex 5. Social Security Number **Funeral** Months Days 228-50-893 1X M 2□ F Director irainia Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a Stete 10h County f Haalth and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, the Medical Examiner must be notified at 1⊠Yes 2□No Director Marylana more 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status filed within 72 hours aftar 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0020 þ Specify 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) i ea 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) å 8 Important: If item 27 is marked any injury or other traumatic ex Dag ulla ဥ 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) (Sister) 23224 240 hmond 20b. Plece of Disposition (Neme of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Date tery, crematory or other place) Department of 1 ■ Bunal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Kag Virginia tamily Cemetery 22. Name and Address of Facility Joseph L. Rus 21. Signature of Funeral Service Licenses Funeral Ha Home Russ 2222 W. North 1216 Ave. that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, e on each line. Approximate Interval Between Onset and Death Enter the disease, or complications that or heart is lure. List only one cause on Physician eau Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of): Examiner The law requires that the death certificate be executed ed by tha attending physician and datached for use as tha burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? Division of Vital Records, P.O. signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of deeth? cata has been sig , page 2 should b 24a. Wes an autopsy performed? Completed After this cartificata has 2.2 No 1 ☐ Yes 2 전 No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient з□ DOA 4₽ Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpetient within 24 hours after death.

To the Funeral Director: After this completely fillad in by the funeral of 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) 28h Time of 28d. Describe how injury occurred 27. Menner of Death Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A 4 Homicide Hospitai 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai To the 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of certifier Sucian

State Registrar

Registrar FEB 2 0 2004

32. Registrar's Signeture

JOCA

address of person who completed cause of death (Item 23e) (Type, Print)

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31. Date filed (Month, Day, Year)

back

Kaven Blvd

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 05482 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dey Month Year Walters 6:53 AM **Physician** 02 2004 Alexander /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore est Bouthnore ewinital Sanantan Good If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Min. **Funeral** 1 M 2 □ F 215-24 Director Usual Residence of Deceder 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show th and Mental Hygiene. 27 is markad other than "natural", or Itams 23a or 28a-1 show traumatic avant, the Medical Examinar must be notified at 1 Yes 2 No BALTIMORG Director BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 WORTH da Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) counta HCCOUNTIN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Walters Hlexander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTIMORE nt of Health alter other Date 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 6 -21-04 permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ALTIMORE MD 21. Signature of Funeral Service Licenses EVANS FUNERAL CHAPEL, 8500 HARFORD RD MURCLA 23a. Pert1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ranse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EMBOUSM PULLONARY OSSIBLE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPTIC SHUCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner aptiel or Attending Physician: The law requires that the death certificate be executed rours after death.

nerel Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit PNEUMONIA resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23h Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 Yes 2 No 3 Probably LUNG CANCER 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 XNo 24a. Was an COWN CANCER autopsy performed? Obstructive 1 Yes 2 No Chronic Ulmoran 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide determined 4 Homicide within 24 hours a To the Funerel L 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature, and title of certifier Medical Resident RES 02/19/04 000 20th 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMURE MD-21239 HOSPITAL. G000 Smmar 17 KASNISM MISHRA 32. Registrar's sgnature 31. Date filed (Month, Day, Year) State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 05483 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 02/19/2004 **Physician** John P. Wolff, 9:37 am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 507 E. Clement Street Baltimore City N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6 Sex 5. Social Security Number 214-20-5494 **Funeral** 76 Days XXM 2 F 09/26/1927 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Itams 23s or 28s-f show permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylai Department of Heath and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Neutcal Examinat must be notified at MD N/A Baltimore City 1 TYPYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 507 E. Clement Street 21230 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 GYes 2 No Army 179s, Give 46-4 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 🔀 Married Maryland 21215-0036 46-47 1 ☐ Yes → No Specify Specify: þ white 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Carpet Carpet Layer 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edward W. Wolff Mollie McHale 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John P. Wolff, Jr. / Son 507 E. Clement Street, Baltimore MD 21230 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Toremation 3 ☐ Removal from State Bayview Crematory Feb. 20, 2004 Baltimore MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eurored Service Licensee Victor P. Doda 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition HYMOXEMIA Physician 4 resulting in death) /Medical Due to (or as a consequence of): Examiner TRUCTIVE LUNG DISFAIR KROMC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, signed by the attending physicien Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No should ! Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 this in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident al or Attend after death Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours a To the Funeral L completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert/fler 0 96 Y D 3 30. Name and address of cerson who completed cause of death (Item 23a) (Type, Print) S. HAVOVER SUFI MARC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FFR 2 n 2004

**ORIGINAL** 

	1 - State Registrar				Ce	artment of F	Death	2. Date of D	Reg. No		4 0548
n	1. Decedent's Nan	ne (First, Middle, L	sylvia	Renn	Wrigh	nt		Month	Da	y Yeer .8, 2004	
r	4a. Fecility Name	(If not institution, gi	ive street and number	r)		4b. City, Town, o	r Location of Death			. County of Dec	
ı	Laurel	Regional	Hospital			Laurel			F	rince (	George
	5. Social Security		Sex 7. A 1 M 2 ☑ F	•	last birthday Yrs.	Months Days	Il Under 24 Hrs. Hours Min.	8. Date of Bi	ay, Year,	) (	rthplace (State or Foreign
-	217-30- Usuel Residence			91	113.			May 20	, 19	12 Mai	ryland
1	10a. State	10b. County		10c. Cit	ty, Town or L	ocation					10d. Inside City Limits
	MD	Montgor	nery	Bu	rtons	ville					1 ☐ Yes 2 ☑ No
	10e. Street and N	umber				10f. Zip Code			10g. Ci	tizen of What C	Country?
	3801 Be	ll Road				20866				.A.	
	11. Marital Status		12. Was Deceden Armed Forces	:?	.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh	
1	_	rried 2 Married 4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates			1 ☐ Yes 2 🔯 No	Specify:			Specify: Wh	ite
-	3 X MIGOMEG	15. Decedent's		•	16a. Dec	edent's Usual Occup	pation		16b. K	(ind of Busines	
		cify only highest g	rade completed)	· F · \	(Giv	e kind of work done DO NOT use retired	during most of work	king			,
l	Elementary/Sec	condary (U-12)	College (1-40)	3+)	Homer	naker			Ow	n Home	
1	17. Father's Name	(First, Middle, Las	st)				18. Mother's Nam	e (First, Middle	, Maider	Sumame)	
	George	Renn					Louise	Feighn	∋у		
ľ	19a. Informant's I	Name/Relationship	(Type, Print)		19b. Mai	ling Address (Street	and Number or Ru	ral Route Numb	er, City	or Town, State,	Zip Code)
	Walter	W. Wright	/son		320	Adams Roa	ad, Elton	, Tenne	ssee	38455	
	20a. Method of Di		☐Removal from Stat		Place of Disp cemetery, cr	osition (Name of ematory or other plac	сө)	Date	20c. L	ocation - City o	r Town, State
		5 Other (Spec			ion Ce	emetery	Feb	21, 04	Bur	tonsvil	lle, Marylan
	21. Signature of F	uneral Service Lic	ensee		1	22. Name and Addre Donaldsor	ss of Facility	Home.	P.A.		
	Lau	Le Klan	refran	M001	60						20707-4389
	23a. Part : Enter shock, or he	the disease, or co	mplications that cause y one cause on each	ed the deat line.	th. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Immediate Cause disease or condit		Aspira	tion	pneumo	onia					Onset and Death
	resulting in death		Due to (or a		-						
	Sequentially list of	onditions,	b								
	Sequentially list of any, leading to cause. Enter Uno	deriving	Due to (or a	is a conseq	(uence of):						
	Cause (Disease of that initiated even resulting in death	ts	c Due to (or a	is a conson	mence of).						
			Due 10 (01 a	is a conseq	derice or).						
		•	d								
	IF FEMALE:		23c. If yes, outcom	e of pregna	ancv					22d Data of de	olivon
	23b. Was deceded in the past 1	2 months?	1☐Live birth	2 Feta	al death 3	☐Ectopic pregnancy ☐ Other (specify)	У			23d. Date of de Month	Day Year
	1 ☐ Yes 2 9 ☐ Unknow		9□ Unknown								
	Part II. Other sign	nificant conditions	contributing to death	but not res	sulting in the	underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
	Alzheim	er's deme	entia					1 🗆	Yes 2	[XNo 3 □ F	robably 4 Unknow
								24a. Wa:	s an	24b. Were a	autopsy findings availabl
-								auto	opsy ormed?	prior to death?	completion of cause of
	05 1Man ann sal	anned to madical						1 Yes		1 Ye	s 2 No
	25. Was case rel examiner?		Hospital:	tiont 2	I E B/Outpati	Oth	26. Place of Dea			s 🗆 🗆	
	1 Yes 2					of 28c. Injur	y at				өспу)
	1 XNatural 2 ☐ Accident	5 Pending investigat	1	Day Year)	y Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Work? 1   Yes 2   No						
	3 Suicide	6 Could not	be 28e. Place of I	njury - At h	ome, larm, s	treet, factory, office		28f. Location	(Street a	nd Number or F	Rural Route Number,
	4  Homicide	) Getorrinie	building,	etc. (Specii	fy)			City or To	wn, Stati	Θ)	
	29a. Certifier (Check only	1 X Certifying I 2 Medical Ex	Physician: To the besaminer: On the basis	of examina	owledge, dea ation and/or	ath occurred at the tir	me, date and place, ppinion, death occur	and due to the	cause(s	and manner a d place, and du	as stated. ue to the cause(s)
	one) 29b. Signature ar	nd title of Cartifier	and manner	stated.		29c. Licens	e number		29d. Da	ite signed (Mor	oth, Day, Year)
	<b>)</b> –	Soma	M /In	M	4	D544	188		Fo	b 18, 2	004
	30. Name and ad	dress of person wh	o completed cause of				100		ге	N 10, 2	.004
		So, M.D.				Laurel, M	1D 20707				
	31. Date filed (Mo	onth, Day, Year)	\$2. Regis								
		B 2 0 200	A SOR	PE	P. May	SER.					

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

05485 State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) WALTER Month **Physician** 3.20 2004 re brusing /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number, Examiner Harborside - Harford Gardens Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, OCt. 7, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1□ M 2□ F Maryland 80 215-12-9295 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County I Health and Mental Hygiene. Item 27 is marked other than "naturel", or Itams 23s or 28e-f show other treumstic event, the Medical Examiner must be notified at 1 Yes 2 ☐ No Director Baltimore N/A 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code U.S.A. 21206 4403 Frankford Avenue by Funerai 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within 72 tonent of Health and Mental Hygiene. ent: If item 27 is marked other than "nate College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Beckman Joseph Walter 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4403 Frankford Avenue Baltimore, Maryland 21206 Raymond Schwarzer - Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Pege Department of Importent: If any Injury or once. Hilltop Service Corp. 2/20/04 Towson, Maryland 21214 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Heather Cain 5305 Harford Road Baltimore, Maryland 21214 carrier 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 XIVo has 1 ☐ Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Funeral 29a. Certifier Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud. doch avar 32. Registrar's Signature 31. Date liled (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ysicia		1. Decedent's Name ( David Wa		e, Last)								2. Date of D Month Febru	Da	y 18.	Year 2004	3. Time of Death
ledica		4a. Fecility Name (If n		n, give str	reet and nun	nber)		4b. City,	Town, or	Location	of Death	repro			of Death	/:25 P
amine	er	Sinai Hos						Bal	timo:	re			N	/A		
eral		5. Social Security Nur	-	6. Sex		7. Age (In yr	rs. last birthday)		r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of B (Month, L Nov 2	irth		9. Birthp	tace (State or Foreign
ctor		215-02-06	666	1 □7	¥ 2□ F		24 Yrs.	Morning	Cays	110013	N. I.	Nov 2	8, 1	979	Mary.	lánd
	-	Usuat Residence of D	ecedent 10b, County			100.0	City, Town or Le	ncation							1	0d. Inside City Limits
		1				1										1 AYes 2 No
	Director	MD	N/A			Ва	altimore	10f. Zip	o Code				10g Cit	tizen of V	What Cour	ntry?
E E	吉	10e. Street and Numb			A-+ 2	206			216						Stat	-
Inst	Funeral	2503 Viol	et Av			edent Ever in	IU.S. 13.			spanic Or	igin? (Spe	ecify Yes or N			e - Americ	
in in	in in	11. Marital Status  1 Never Married	d 2□ Mar		Armed Fo	rces? 2 (TNo		If Yes, spe	cify Cuba	n, Mexicai	n, Puerto	Rican, etc.)			ck, White,	etc.
i i	by	3 ☐ Widowed 4			If Yes, Giv Year or Da	/B		1 🗌 Yes	2 No	Specify:				Specify <b>Bla</b>	ck	
and a	ted	1	5. Deceder	nt's Educa	ation		16a. Dece	dent's Usu	al Occupa	ation	t of worki	ina			usiness/In	dustry
raumatic event, the Madical Examinar must be nutitled at	Completed	(Specif) Elementary/Second	y only higher dary (0-12)	si grade	Completea)	-4or 5+)	`life.	DO NOT u	ise retired	)		9	N/I	A.		
1	Ö	11					None									
ž į	Be	17. Father's Name (F									_	(First, Midd	le, Maiden	n Suman	ne)	
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Ě		19a. Informant's Nan						-				al Route Num				
ner fr		Ms. Emma		-Gra	ndmoth		b I b			ntior		enue, . Date	-		- City or To	21205
or other traumatic		20a. Method of Dispo		3 □Re	moval from	State	cemetery, cre	matory or o	other place			Feb 24				
2		`4 □Donation 5			A-		Mt. Zio			-	-	2004	Ba.	TCIM	ore,	
any injury or other tra- once.		21. Signature of Fund	eral Service	Licensee	the	7			n L.	Will	liams	Funer e Stre				e, MD
cian lical iner		shock, or heart Immediate Cause (F disease or condition resulting in death)	failure. Lis	r complicationly one	Mult Gune	iple g	eath. Do not engunshot ound of sequence of):	wound	de of dying	g, such as	cardiac o	or respiratory	arrest,			Approximate Interval Between Onset and Death
al er	ai Examiner	shock, or heart Immediate Cause (F disease or condition	failure. Listinal ditions, mediate lying litury	a. b. c.	Cuns Due to	iple general sections as a cons	eath. Do not en gunshot ound of	wound	de of dying	g, such as	cardiac o	or respiratory	arrest,			Approximate Interval Between
ached for use as the buria-transit	dicai	shock, or heart Immediate Cause (F disease or condition resulting in death)  Sequentially list cond if any, leading to imm cause. Enter Under Cause (Disease or in that inflated events	ditions, notical ditions, notical ditions, notical ditions, notical ditions, notical ditions, notical ditions, notical ditions, notical ditions, notical distributions, notical distrib	a. b. c. d.	Due to  Due to	iple general acons (or as a cons) (or as a cons) (or as a cons) (or as a cons)	eath. Do not engunshot ound of sequence of): sequence of): sequence of): sequence of):	wound	de of dyind ls wi O wit	g, such as	cardiac o	or respiratory	arrest,	23d. Da	ate of delive	Approximate Interval Between Onset and Death
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State of Maryland / Department of Health and Mental Hygiene 104 05487 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 47 AM **Physician** Feb 2004 Gertrude Zentz /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hartoro Mariner F 5. Social Security Number Health AIr 11 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖫 F 86 July 6, 218-09-2645 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Parkville Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2319 Covered Bridge Garth U.S.A. 21234 death Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) A T & T 8 yr's Switchboard Operator Peges 1 and 2 should be filed vitnent of Health and Mental Hygie tant: If Item 27 is marked other jury or other traumatic event, III. 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be William F. Sr. Gertrude Aestor Lemmon, ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. Lemmon - Brother 2319 Covered Bridge Garth Baltimore, MD 21234 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Pege Department o Important: If any injury or Gardens of Faith 2/20/2004 Baltimore, MD 22. Name and Address of Facility Baltimore, Maryland 21. Signature of Funeral Service Lip 90UC 5305 Harford Rd. Leonard J. Ruck, Inc. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Werks **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Examiner death certificate be executed Due to (or as a consequence of): by Physician/Medical attending phys IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐Unknown 1 Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy 2 No Hospitel or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. within 24 hours after deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D34652 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Bel Air Manylong North Scoff 31. Date filed (Month, Day, Year) State 2 0 2004 Registrar

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Y	Funeral Director		212-17-7113	Sex 1∭ M 2□F	7. Age (In yrs.	Yrs.	Months	r 1 Year Days	If Under Hours	Min	8. Date of Bir (Month, Da March	Year 14,	1979	Countr	ce (State or Foreign Y) Laware
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0 0	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	_ a		tethado: quence of):	ne Ir	toxi	catio	on					Onset and Death
O .	p ==	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (c	or as a consec	uence of):		-							
8760,	ate be executed only sician and the burial-transit	dicai Exar	that initiated events resulting in death) Last	c. Due to (c	or as a consec	quence of):									
Вох 68	leath certifica attending ph	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregnath 2 Feta		DEctopic p						23d. Date of	delivery	,
P.O. B	at the deatl by the atte tached for	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown		int at time of c		Other (s						Month		ay Year
	es this igned be de	by	Part II. Dther significant conditions	contributing to de	ath but not res	sulting in the u	nderlying	cause give	en in Part I	1.					cause of death?
Vital Records,	e law requir has been si je 2 should	Completed									24a. Was		24b. Were prior deat	to comp	sy findings available pletion of cause of
<u> </u>				,							1 Yes	2 □ No		Yes 2	□ No
Vita	Physician: Th this certificate ral director, pag	Be o	25. Was case referred to medical examiner?	Hospital:		150/0 · · · · · ·		OA Othe	ar-		Check only		0.5300000000000000000000000000000000000	2	7+
of	Phys r this ral di	. To	No 27. Manner of Death	1 L Ir	f Imiran	ER/Outpatier _28b. Time of		28c. Injury Work	4 🗆 140		me 5 Resi 28d. Describe			opecity)	At scen
on	iding P th. : After funer	tion	1 ☐ Natural 5 ☐ Pending 2 ☐ Accidentinvestigation		n, Day Year)	Found 1:38	рм	Work	Yes 2	No	Unkno	wn			
Division of	l or Attending atter death. Director: After In by the fune	ifica	3 ☐ Suicide 6 ☐ Could not	28e. Place	of Injury - At h	ome, farm, str	eet, factor	y, office					nd Number of	Rural I	Route Number erick St.
Dİ	F e F C	Certification:	4  Homicide		g, etc. <i>(Speci</i> i <b>l at h</b> o	•				C	charles	town	, Md	1 EU	CITCK DL.
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical C		hysician: To the miner: On the ba and mann	best of my kno	owledge, death				nd place,	and due to the	cause(s	and manne		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. 1.			29	c. License	e number			29d. Da	ate signed (M	onth, Di	ay, Year)
			Mayante (1)	ne Uhre	le,			O.C.M	E.			Jan	uary 3	31,	2004
	6		30. Name and address of person who	completed cause	of death (Iter	т 23а) (Туре,	Print)							· · ·	
	Sta	te.	31. Date filed (Month, Day, Year)	KOREU 32. Re	igistrar's Signa	ature	11:	1 Pen	ın Stı	reet,	Balti	nore	e, Mary	lan	d 21201
	Regist		FEB 0 4 2004	Heren	, K	Goode	j								

		•	For State Registrar	State of Marylar	nd / Depa <i>Cel</i>	artment of Ho <i>rtificate of L</i>	ealth and M Death		giene Reg. No		+ 05490
	\$8		Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	v Yeer	3. Time of Death
i ne	Physicia /Medic		Virgie Loui		5	1		Februa	ary '	9, 2004	9:00 A.M
Tree	Examin	-16	4a. Fecility Name (If not institution, give str			4b. City, Town, or Brand				County of Deet rince Ge	
	Farmana	is de	8304 Rison Driv 5. Social Security Number 6. Sex		. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th	9. Birt	hplace (State or Foreign
	Funeral Director			2XIF 87	Yrs.	Months Days	Hours Min.	April 6			st Virginia
	pu		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation		1			10d. Inside City Limits
	Maryla f sho	-0	Maryland Prince Geo	orge's Br	andywi	ne					1 Yes 2 No
	r 28a-	Director	10e. Street and Number			10f. Zip Code	, , , , , , , , , , , , , , , , , , , ,		10g. Cit	izen of What Co	ountry?
	th with	aî D	8304 Rison Drive			206				U.S.A.	
	tems	Funeral	TI. Wallar States	. Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, Whit	
200	irs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 ▼No If Yes, Give X Year or Dates:		1 ☐ Yes 2 No	Specify:			Specify:	White
20-0	tiled within 72 hours after death with the Maryland Hygiene. Ithy than 'natural', or items 23a or 28a-f show sht, the Mudical Exemitive instal be notified at		15. Decedent's Educa (Specify only highest grade of			dent's Usual Occupa		ina	16b. K	ind of Business	Industry
Z	ithin 7 ne. hen "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,					
7	iled w Tygier ther th		17. Father's Name (First, Middle, Last)		Caf	eteria Wo	rker 18. Mother's Name	e (First, Middle			overnment
yland	id be i ental ked o	To Be	Grover Simons				Lillv	Caldwe:	11		
C.	shou and M mar	-	19a. Informant's Name/Relationship (Type			ng Address (Street a	nd Number or Run	al Route Numb	er, City o		
, Ma	and 2 ealth a n 27 i		Shelby J. Stevens			Rison Dr		ndywine		ryland :	
ore	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatin and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show amortant: If item 27 is marked other than "natural," or items 23a or 28a-f show amortant in items 27 is marked other than "natural".		20a. Method of Disposition  1 Burial 2 Tremation 3 Ref	noval from State	cemetery, cre	osition (Name of matory or other place	9)			,	
Saltimor	it. Pertrant		* 4 □Donation * 5 □ Other (Specify)  21. Signature of Funeral Service Licensee			natory Feb 2. Name and Addres				nton, Ma	
n n	permi Depar Impo any ir		1 K-00 R (	Patter							land 20735
b			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	tions that caused the dea							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		STAT	IC CE	RVICA	L CA	NO	ER	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):						·
ũ		er	Sequentially list conditions b. if any, leading to immediate	Due to (or as a conse	quence of):						
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.								
Ď	icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):						
09/8	cate b physic the b	dical	d.								
ROX	death certifi e attending id for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregi						23d. Date of de	livery
	death	sicia	in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown		□Ectopic pregnancy □ Other (specify)				Month	Day Year
J O	that the death certif ed by the attending detached for use a:	Physician/Me	9 ☐ Unknowfi  Part II. Other significant conditions conti		eculting in the	Inderhina cause awa	on in Part I	23a Did t	obacco	usa contributa to	o the cause of death?
ďS,	Se P 90	by	Part II. Other significant conditions conti	ibuting to death but not re	southly in the t	andenying cause give	ariti raiti.	1		37	robably 4 Unknown
ecords,		Completed						24a. Was		24b. Were at	utopsy findings available
r	sicien: The law certificate has l rector, page 2 s	omp						auto perfo	psy ormed? 2 A No	death?	completion of cause of
Vital	ien: srtifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Deat				
0	Physicien: this certific ral director,	ို	1 ☐ Yes 2 No		ER/Outpatie		4   Iduising Fic	ome Zafesi 28d. Describe		6 Other (Spe	ocify)
uo	ding F h. After funera	tion:	27. Manner of D ath 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	rat (? Yes 2 □ No	Zod. Describe	riow niju	ry occurred	
Division	I or Attendi after death, Director: A I in by the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	treet, factory, office		28f. Location ( City or To			ural Route Number,
	spitel or A ours after seret Directilled in by	Certification:	4   Homicide	busing, atc. (Space	y)			0.1.7 0.7 70	wii, Olale		
	는 를 들어	edical		cian: To the best of my ki ir: On the basis of examinand manner stated.							
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier			29c. License			29d. Da	ite signed (Mont	th, Day, Year)
			* Britis MD			D 4	3346		2	1410	4
5	RIN		30. Name and address of person who com Rita Gupta, M.D.	pleted cause of death (Ite	em 23a) (Type	, Print) #201 C1	inton Ma	rvland	207	35	
d	Sta	ate	31. Date filed (Month, Day, Year)	32. Pegistrar's Sig	nature	1 1201, OI		,			
	Regist		FEB 1 0 20	32. Pigistrar's Sig	S. A	pour					

		State  1 - State RegistrarAMEND ITEM16b&19a PER	of Maryland / E FH G828 2/26/	Departme <b>(Le<b>r</b>tifica</b>	ent of F ate of i	lealth and Death	Mental Hy	giene Reg. No		+ 05491
Dhuei	ian	Decedent's Name (First, Middle, Last)					2. Date of De	sath Da	y Year	3. Time of Death
Physic /Med		Shirley Kay Beal						ry	6,2004	
Exam	iner	4a. Facility Name (If not institution, give street and	nu <i>mber)</i>			r Location of Deat	n	40	. County of Dee	
-		6135 Goode Road  5. Social Security Number 6. Sex	7. Age (In yrs. last bin	thday) If Un	der 1 Year	ville If Under 24 Hrs		rth .	Charl	thplece (State or Foreign
Funera Directo		549-52-1155 1□ M 21 PF	64	Yrs. Month	ns Days	Hours Min.	Feb. 1		CC	linois
p .		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Legation						10d. Inside City Limits
anylar show	ž									1 ☐ Yes 2 € No
the M	Director	MD Charles 10e, Street and Number	Hughes		Zip Code			10a. Cit	izen of What Co	ountry?
leath with the Marylan ns 23s or 28s-f show mast be notified at		6135 Goode Road			20637	7		Π.	S. A.	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. kther then "natural", or Itams 23a or 28a-1 show ent, the Medical Exemination multipad at	Funeral	11 Marital Status 12. Was D	ecedent Ever in U.S. Forces?	13. Was De		lispanic Origin? (S an, Mexican, Puer	pecify Yes or No		14. Race - Ame Black, Whit	
arter or its		1 Never Married 2 Married 1 Ye	s 2⊠No Give		20 <b>2</b> 0000	Specify:	10 / 110411, 010.)	ĺ	Specify:	0, 010.
21215-0036  I within 72 hours after dealiene. Ithen "natural", or Itams Ita Medical Examirer m	d by	3 ☐ Widowed 4 ☒ Divorced Year o	r Dates:	Decedent's U	loval Ossva	ation		1 seb K		ite
n 72 in 72	oiete	15. Decedent's Education (Specify only highest grade complete	d)	(Give kind of life. DO NO)	work done of use retired	during most of wo	rking	100. 1	and or business	inicustry
ZTZ	Completed	Elementary/Secondary (0-12) College 12	Ex	ecuti	ve Se	ecretar	у	Air	line	AEROSPACE
be filed that Hyg of othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, <i>Maid</i> en	Sumame)	
arylan, should be and Mental marked o	10	Leonard Ressell Brya				Mary P				
2 2 a a		19a Informant's Name/Relationship (Type, Print) ANDREA				and Number or Ru		505		
C = 14 F		Andria Robinson/daug	20b. Place of	Disposition (A	Vame of	Road Hu	Date		ocation - City or	
Pages nent of nnt: If it		1 ☐ Burial 2 XCremation 3 ☐ Removal fro '4 ☐ Donation 5 ☐ Other (Specify)	m State	ry, crematory o i o 1 d F c			uary	Cha	rlotte	Hall MD
Baltimore, permit. Pages 1 a Department of He Importent: If item any injury or othe		21. Signature of Funeral Service Licensee	DITHSI.	22. Name	and Addres	ss of Facility Br	insfie	Id-E	chols	Hall, MD FuneralHom
n abes		Houn Set Jul	<b>M</b> 00641	3019	5Thre	ee Notc	h Road	, Cha	arlotte	eHall,MD
		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause o	at caused the death. Do r n each line.	not enter the m	node of dyin	g, such as cardia	or respiratory a	rrest,		Approximate fnterval Between Onset and Death
Physiciar		fmmediate Cause (Final disease or condition a.	Schenic	he	ort	Disea	ise			Oriset and Death
/Medica Examine			to (or as a consequence of		ŕ					
	. i		to (or as a consequence of	of):						
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
O, exec an an rial-tr	Exa		to (or as a consequence of	of):						
S8 760, icate be executed physician and s the burial-transit	edicai	d.								
	/Med	IF FEMALE: 23c If yes	outcome of pregnancy						23d. Date ol def	i von
ecords, P.O. Box 6 law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/M	in the past 12 months?	e birth 2 Fetal death	3 ☐Ectopic 5 ☐ Other					Month Month	Day Year
by the a	hysi	9 Unknown 9 Un	known							
S, P res that igned b be deta	by P	Part II. Other significant conditions contributing to	death but not resulting in	the underlying	g cause giv	en in Part I.				the cause of death?
w require been signature							10	Yes 2	□No 3□Pr	obably 4 Dunknown
Kecords, he law requires t e has been signe age 2 should be o	Completed						24a. Was auto	psy	prior to	topsy findings available completion of cause of
	So						1 ☐ Yes	ormed? 2X No	death?	2 No
Of VITAL Physicien: The This certificate ral director, pag	Be	25. Was case relerred to medical examiner?  1 🖼 Yes 2 🗌 No Hospitaf: 1	☐Inpatient 2☐ER/Out	tpatient 3	DOA Oth	26. Place of Dea	ith <i>(Check only i</i> lome 5 <b>⊠</b> Resi		c Dother (Co.	-14.)
Phy Phy rald	n: To	27. Manner of Death 28a. Da	te of Injury 28b. T	Time of	28c. Injun		28d. Describe			city)
USION ( ttending F death. ctor: After y the funer	atio	2 Accident investigation	onui, Day ( ear)	njury M		Yes 2 □No				
DIVISION If or Attending after death. Director: Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Pla	ice of Injury - At home, laiding, etc. (Specify)	rm, street, fact	tory, office		281. Location ( City or To			ral Route Number,
UNISION Hospital or Attending 14 hours after death. Funeral Director: Attential filled in by the fune										
Hosg 24 ho Fune stely t	Medical	29a. Certifier 1 Certifying Physician: To (Check only 2 Medical Examiner: On the								
To the Hospital or / within 24 hours after To the Funeral Direction completely filled in b	Me	29b. Signature and title ol certifier		2	29c. License	e number		29d. Dat	te signed (Monti	h, Day, Year)
L > F 0		· your m	Tagour		D00°	50883		2-	7-04	+
		30. Name and address of person who completed co	ause of ceath (Item 23a) (						/	
4010		Yahia M. Tagouri, MD	11655 Win	esapp	Plac	ce, La	Plata,	MD	20646	
S Regis	tate	31. Date filed (Month, Day, Year) 32 FEB 1 0 2004	. Registrar's Signature	bou	2					

		1 - For Amend Item Registrar	#11&19a per	informati	Ce.	728/04 rtificati	e of L	Death		,	Reg. No. 2	004	051	492
Physici	an.	1. Decedent's Name (First, Midd	e, Last)							2. Date of De Month	ath Day	Year	3. Time of	Death
/Media	Eileen P. Cook  January 31, 2004									2004 ounty of Death	01:05	) M		
Examir	ier	Union Hospital					kton					Cecil		
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	ıy, Year)	9. Birth Cor	nplace (State o	or Foreign
Director		215-44-1958 Usuel Residence of Decedent		57	Yrs.					July 1	1, 194	46 1	Marylar	ıd
ryland how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside C	•
8a-f s	Director		cil	E	1kton									ŽQN₀
with the		10e. Street and Number				10f. Zip						n of What Co		
death ms 23	Funeral	895 Marley Road	12. Was De	cedent Ever in U	l.S. 13.		2192 dent of Hi		igin? (Sp	ecify Yes or No Rican, etc.)		ed Stat	rican Indian,	
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, ite Waster Landeller in items.		1 Never Married AM Mar	If Yes G	2 🔀 No	1	fYes, spec 1 ☐ Yes :				Rican, etc.)	i	Black, White pec <i>ify:</i> Wh		
hours ural',	d by	3 Widowed 4 MDivorced	Year or	Dates:	16a. Dece									
in 72 n "nat	Be Completed	(Specify only highe	nt's Education st grade completed		(Give	kind of wor DO NOT us	rk done d	turina mos	t of work	ing	160. King	of Business/I	ndustry	
d within giene er than	Com	Elementary/Secondary (0-12) 12	College	(1-4or 5+)	Asse	mb1y	Line	Work	ker		Chrys	sler		
al Hy d othe	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	e (First, Middle,	Maiden Su	rmame)		
should be filed within and Mental Hygiene. s marked other than "umatic event, Ite Mental Control of the Mental Control of the Mental Control of the Mental of the Mental of the Mental of the Mental of the Mental of the Men	ပ္	Adam Shipley			401 44 11		10		y Gi					
d 2 sho th and 7 Is m traum	114	19a. Informant's Name/Relations		companion		-				al Route Numbe			ip Code)	
Health Health tem 27 I		Charles E. Wils 20a. Method of Disposition	on, Sr./-	pouse 20b. F	Place of Dispo	sition (Nan	ne of		- (	on Mar		tion - City or 1	Town, State	
		1 🖾 Burial 2 □ Cremation 1 □ Donation 5 □ Other		No No	rth Ea	natory or o st Me	ther place thod	ist $ ^{\mathrm{F}}$	ebru 2004	ary 7,	Nort	h Faat	, Mary	lan
permit. Page Department Importent: If any injury or		21. Signature of Funeral Service	1	Ce	metery 22	. Name an	d Addres	s of Facilit		uch Fu			, mary	Lan
Depar Impo any ir	V. 1	127 South Main Street, North East, Mary										yland	2190	
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximat Interval Bet Onset and	tween
nysician	1	Immediate Cause (Final disease or condition resulting in death)	_ a. 🗢 🗺	ZEBRO	VASC	MATE	- 1	teer	DE	27			10 D	145
/Medical Examiner		Due to (or as a consequence of):									<i>-</i> 10	male		
	ē	Sequentially list conditions, tary, leading to miniscrate cause. Enter Underlying Cause (Disease or injury	b. 209 to	COR MA A CONNEC	menue of)	TH	i ca	14					> \	19>
outed id ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	s Ac	WIG L	-IVER	FA	114	RE					5 D	AYS
e exection and an arrial-tr		resulting in death) Last	Due to	(or as a consec	uence of):						-			
cate be executed physician and the burial-transit	dica		d						-					
leath certificate be execut attending physician and I for use as the burial-trar	Physician/Medical	IF FEMALE:	23c. If ves. o	utcome of pregna	ancv						224	i. Date of deliv	1001	
ath or u	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Preg	birth 2☐Feta gnant at time of c		Ectopic pr Other <i>(sp</i>					230	Month	,	Year
that the de ned by the a detached f	hys	9 Unknown	9□ Unk	nown										
law requires that the as been signed by th 2 should be detache	þ	Part II. Other significent conditi	ons contributing to	death but not res	ulting in the u	nderlying c	ause give	en in Part I.			_/	7	the cause of	
een s	Completed									1 🗆 🗎				Unknowr
e faw has b	nple									24a. Was autop	an 2 sy rmed?	4b. Were aut prior to o death?	opsy findings ompletion of a	available cause of
n: The licate hi						-				1 ☐ Yes	219No	1 Yes	2 🗆 No	
Physicien: this certific al director,	Be c	25. Was case referred to medica examiner?  1 ☐ Yes 2 ☐ No	Liamital	Inpatient 2	ER/Outpatier	t 3 🗆 DO	Othe	. F.		(Check only o		1011	'6 h	
g Phy er this eral d	n: To	27. Manner of Death	28a. Date	of Injury of, Day Year)	28b. Time of		8c. Injury Work	4 110		me 5□ Resid 28d. Describe f			ity)	
Attending r death. actor: After y the fune	atio	Z C MOOIGOIN	igation	nui, Day real)	Injury	М		r res 2 🔲	No					
or Atterde ifter de Directo in by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 289. Place	e of Injury - At h	ome, farm, str	eet, factory	, office			28f. Location (5 City or Tox	Street and N vn, State)	lumber or Rui	ral Route Num	nber,
urs af urs af ural D	Cel				ъ									
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifyi (Check only 2 Medicel	ng Physicien: To th Exeminer: On the and ma	ne best of my kno basis of examina nner stated.	wiedge, death ation and/or in	occurred restigation,	at the lim in my op	e, date an pinion, dea	d place. th occurr	and due to the ed at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s	s)
ro the within 2 Fo the comple	Me	29b. Signature and title of certific		Δ.		290	. License	number			29d. Date s	igned (Month	. Day, Year)	
7 - 7 - 0		> delmar	4 /	il.		0	000	1463	5		Febr	uary	1, 2	004
-		30. Name and address of person	who completed car	use of death (Iter	n 23a) (Type.	Print)	1	^		treet			מוֹחַ	
0		Rolando No. 31. Date filed (Month, Day, Year	10	N.D.	138	Car	the	tra	15	treet	,EI	Kton	INIVA	1921
				Registrar's Signa							,			

		1- For State of Maryland / Department Certificate	of Health and M of Death	lental Hygiene	2004 05493
Phys /Me	ician dical	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	Yeer 3. Time of Death
Exan	niner	FIRILW (a) RIVPRSIDE  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		8. Date of Birth	unty of Death  HHAFILE  9. Birthplace (State or Foreign
Directo	_	Usual Residence of Decedent	Days Hours Min.	December 10, 19.	7
ie Marylar 8a-f show	ctor	10a. State 10b. County 10c. City, Town or Location  HARREDED HARVE DE G			10d. Inside City Limits 1 X Yes 2 □ No
6 after death with the Maryland or items 23a or 28a-f show interinal be nutified at	Funeral Director	10e. Street and Number 10f. Zip C	21078		of What Country?
	<u>م</u>	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Sive Year or Dates:  13. Was Decedent If Yes, Specify 1 Yes, Sive Year or Dates:	nt of Hispanic Origin? (Spe y Cuban, Mexican, Puerto I XNo <i>Specity:</i>		Race - American Indian, Black, White, etc. ecity: WHITE
21215-0036 within 72 hours after liene.	To Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual (Give kind of work life. DO NOT use	done during most of workir retired)	ng	of Business/Industry  mph Explosive
re, Maryland 2121 re, Maryland 2121 s 1 and 2 should be filed withir feath and Mental Hygiene. flem 27 is marked other then other treumatic event, treum	To Be C	17. Father's Name (First, Middle, Last)  ODEN HOWINGSWORTH	No	(First, Middle, Maiden Sur INFORMAT	mame)
PS+ Ma Dre, Ma Bs 1 and 2 & of Health ar Filtem 27 is			of place)		21/21
Baltimo permit. Pag Department importent: i	ODCe.	21. Signature of Funeral Service Licensee  Licensee  22. Name and 43 DREU FUNER.	Address of Facility  Of. GEE  AL HOME, PA	259 Elk	E. MAIN ST TON, MS
8760, % sale be executed was in thysician and the burial-transit	al	23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):	r aceir	ular d	Interval Between Onset and Death
Box 6 Bath certific attending p	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  Yes   9  Unknown 23c. If yes, outcome of pregnancy   1  Live birth 2  Fetel death   4  Pregnant at time of death   9  Unknown		23d.	Date of delivery Month Day Year
ds, P.	þ	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.	23e. Did tobacco use c	contribute to the cause of death?
Division of Vital Records, P.O. after death. Director: After this certificate has been signed by the linby the funeral director, page 2 should be detached	Completed			24a. Was an autopsy performed 1 Yes 2 No	Were autopsy findings available prior to completion of cause of death?     1 ☐ Yes 2 ☐ No
Vital F sicien: Th s certificate lirector, pag	Be	25. Was case referred to medical examiner?  1   Yes   2   Yeo   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA	26. Place of Death Other:	(Check only one)	Other (Specific)
Division of Vital Reform to the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation; To	27. Manner of Death    28a. Date of Injury (Month, Day Year)	144	8d. Describe how injury oc	
<b>1</b>	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	ffice 2	8f. Location (Street and Nu City or Town, State)	imber or Rural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control of the best of my knowledge, death occurred at a control occurred at a control occurred at a control occurred	the time, date and place, at my opinion, death occurre	nd due to the cause(s) and d at the time, date and place	manner as stated. ce, and due to the cause(s)
To the comp	M	29b. Signature and title of certifier 29c. L	icense number 6	29d. Date sig	gned (Month, Day, Year)
2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	tou St. 1	Havre do	Grace MD
S Regis	itate strar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			21078

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** February 7:15 p Dorothy May Cook 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F 85 Yrs. March 19,1918 Pennsylvania 579-36-1538 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-1 show r than "natural", or items 23s or 28s-f show It is Medical Exactions must be rediffed at 1 ☐ Yes 2√ No Directo Maryland Anne Arundel North Beach Park the 10g. Citizen of What Country? 10e. Street and Number 814 Cedar Avenue 20714 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other then Dry Cleaning Owner, dry cleaner 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othu any injury or other traumatic svent, ang. Charles Frederick Betton Mary Bateman Hibbert 19a Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Cook, daughter 7017 Albany Ave., Rose Haven, North Beach, MD 20714 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 MCremation 3 Removal from State
4 Donation 5 Other (Specify) Metropolitan Crematory 2/10/2004 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Failure ix month /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and physician ar Box 68760 Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 □Unknown been signature Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy s certificate ha 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Dinpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and Mg of certifier 29d. Date signed (Month, Day, Year) e of person who completed cause of death (Item 23a) (Type 1655 31. Date filed (Month, Day, Year, 32. Registras Signature State EB 11 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene

			Certificate	of Death	Re	g. No.	05495
			1. Decedent's Name (First, Middle, Last)		2. Date of Deetl Month	Day Yeer	3. Time of Death
	Physici /Medio		Virginia Bowen Cranford		February	31	7:05 a.m.
	* Examir		4a Facility Neme (If not institution, give street and number)	4b. City, Town, or L	ocation of Deeth	4c. County of Death	
			Asbury Solomons Health Care Center	Solomon	s	Calvert	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Y Months D	rear If Under 24 Hrs. eys Hours Min.	8. Date of Birth (Month, Day,	Yeer) 9. Birth	plece (Stete or Foreign ntry)
	Director		216–14–5431 1 M 2 F 86 Yrs. Months		Nov. 23	,1917   Mary	land
	pud *		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
	sho	ъ					1 ☐ Yes 2 💢 No
	the N	to e	Maryland Calvert Solomons  106. Street end Number 10f. Zip Co	de	10	og. Citizen of What Cou	ntry?
	With With	Funeral Director	11750 Asbury Circle 206			U.S.A.	
	aath	era	11 Menital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	t of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri	
_	ther	ᆵ	Armed Forces? If Yes, specify	Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
20	ors a		1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Detes:	No Specify:		Specify: Wi	nite
Ą	2 hor	Completed by	15. Decedent's Education 16a. Decedent's Usual O	ccupetion lone during most of work	ring	16b. Kind of Business/In	dustry
2	hin 7	를	(Specify only highest grede completed)  (Give kind of work diffe. DO NOT use not be seen to be seen the seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen to be seen t	etired)	9		
7	od wil	点	12 home make:			own home	<u> </u>
B	al Hy	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, N	faiden Surname)	
<u>ya</u>	Mant Mant Mant Mant Mant Mant Mant Mant	ဥ	Maurice Franklin Bowen	Sarah	Jennie	Lyons	
lar	2 she and ie ma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Si				
~	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Martial hygiene. Item 27 is marked other than "naturel", or frems 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at			ng Creek Rd		ngtown, MD	
Baltimore, Maryland 21215-0020	or oth	1	1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State	r place)			
Ë	permit. Pages Department of important: if if any injury or once.		4 Donation 5 Other (Specify) Emmanuel Church		/11/2004	Huntingtow	n, MD
3a	permit. Pa Departmen important: any injury	- J		ddress of Facility			
	00 % e o		Deya / lebail Rausch Fr	uneral Home	, P.A.	Owings, MD	20736
			23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or hear fullure. List only one cluse on each line.	dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition Right Pariety)	D.J.	Indas	Eclin !	1 win
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. Mous	O.C.		
		<u>.</u>	Due to (or as a consequence of):				0
Ξ	ped tist	edical Examine	b			<u> </u>	
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89	ficeta p phy as the		resulting in death) Last			į	
Вох		7	d		-	- 1	
	e law requires that the death ce has been signed by the attandi ge 2 should be detached for use	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying caus	e given in Part I.	23b. Did to	bacco use contribute t	to the cause of death?
P.0	by th	J.	Chrime A. Februlleli-		1 □ Y	2 No 3 Pro	bably 4 Unknown
	gned gned se de	by F					
ğ	en si	8			24a. Was ar perform	ned? av	Vailable prior to
၁၁	aw re 1s be 2 sh	ple					ompletion of cause death?
æ	The I	Completed			†□ Ye	5 2 No 1	□Yes 2□No
of Vital Records,	ian: ortifica ctor,	Be	25. Was case referred to medical examiner?	1	th (Check only on	9)	
<u></u>	Physician: this certific ral director,	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA			nce 6 □Other (Speci	(y)
ם	ng Pt fter tf inera			Injury at Work?	28d. Describe ho	w injury occurred	
Sio	Attending ir daath. ector: After by the fune	cat	2 Accident investigation	1 ☐ Yes 2 ☐ No	001 11 (01		- / Courte &/v = hor
Division	or Att	Certification:	4 Homicide  3 Suicide  4 Homicide  4 Homicide  4 See Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	tice	City or Town	reet a <i>nd Number or Rur</i> , Stete)	ar Hodie Ndriber,
	ours a prai D		200 Costilior IX Costificion Divisione. To the back of my boundaries doubt conversed at the	he time date and stars	and due to the	usea(s) and manner co	hatefa
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha complately filled in by the funeral director, page	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the control of the basis of exemination end/or investigation, in and menner stated.				
	ithin of the orthe	New Year		icense number	7 25	d. Date signed (Month,	Day, (Year)
	F3F8		ATMAIL Physical D	1942	/	2/9/	0 4
			30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)	1		+	
	15		Anwait T. Munshi, M.D. 110 Hospital Rd. #	303 Prince	Fradori	ar van oo	570
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrate Signature	and a second	TITCUELL	CA, 141 200	710
	Pogiet	'ar	FFR 1 1 2004 Revenue & Sough	N. A.			

		1	For State Registrar	State of	Marylan	nd / Depa	artmen rtificate	t of H	ealth a	and M	ental Hy	giene Reg. No	200	4 05	496
Ī	Physicia	an	Decedent's Name (First, Middle,  KAREN LEE DA								2. Date of De Month Februa	Day	y Year 2004	3. Time o 8:04	
-	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County or								County of Dea	th			
	Funeral					last birthday)	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da			thplace (State ountry)	or Foreign
	Director		217-84-1602 Usual Residence of Decedent	TEM ZA	39	Yrs.					NOV 7	1964	Maı	yland	
	show		10a. State 10b. County  Maryland Montgo	merv		ty, Town or Lo tonsvi								10d. Inside C	City Limits
	r 28a-f	Director	10e. Street and Number	-112			10f. Zip	Code				10g. Cit	izen of What C	ountry?	
	23a o		3004 Greencast1					208					USA	-dan ladina	
36	hours after death with the Maryland turel; or Items 23a or 28a-f show al Examinar must be notified at	by Funeral	11. Marital Status  Y☐ Never Married 2☐ Marrie 3☐ Widowed 4☐ Divorced	12. Was Decedor Armed Force d 1 Tes 2 If Yes, Give Year or Date	es? [XNo		Was Deced If Yes, spec 1 ☐ Yes		Specify:	gin? (Spe i, Puerto f	cify Yes or No Rican, etc.)		14. Race - Am Black, Wh Specify: [		
Maryland 21215-0036	should be filed within 72 hours after death with the Marylar of Mental Hygiene. marked other then "neturel; or liems 23a or 28a-f ehow imetic event, it a Medical Examinat must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  Coltege (1-4	or 5+)	(Give	cedent's Usual Occupation ve kind of work done during most of working b. DO NOT use retired) isabled				ng	16b. Kind of Business/Industry  None			
d 21	filed w Hygier other th	Col	None 17. Father's Name (First, Middle, L	ast)			Babic	<u>.</u>	18. Mothe	or's Name	(First, Middle,				
/lan	should be and Mental marked o	To Be	William R. D	avis					Myra	Har	ris Dav	vis			
Man	2 m m		19a. Informant's Name/Relationsh		- \								or Town, State,		
Baltimore, 1	Pages 1 and 3 nent of Health int: If Item 27 iry or other tr		William R. Dav  20a. Method of Disposition  1 Xi Bunay 2 □ Cremation  1 4 □ Donation 5 ☑ Other (Sp	3 □Removal from St	20b. l	ZZ/O Place of Dispo cemetery, crea njemoy	sition (Nan matory or o	ne of ther plac	e)		ate	20c. L	nd 2060 ocation - City o jemoy,	Town, State	
Baltir	permit. Pages Department of Important: If it eny injury or once.		21. Signature of Funeral Service L		MO01	73	2. Name an	d Addres	ss of Facilit	y Ebe	rwein H	rune.	ral Ser	vices	
	Physician		23a. Part Enter the disease or of shock, or heart failure. List of Immediate Cause (Final disease or condition	omplications that cau nly one cause on each	sed the dea th line. SEPS		ter the mod	e of dyin	g, such as	cardiac o	r respiratory ai	rrest,		Approxima Interval Be Onset and	tween
. 4	/Medical Examiner		resultifig in death)	Due to (or	as a consec	quence of): MONIA									
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,092	te be executed ysician and e burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or	as a consec	quence of):									
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.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ome of pregn h 2 □ Feta ntattime of o on	Fetal death 3 Ectopic pregnancy					23d. Date of delivery Month Day Year		Year			
٥.	juires that t n signed by uld be detar	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Cardio Resporatory Arrest							23e. Did tobacco use contribute to the cause of					
Vital Records,	The law requir te has been si page 2 should	Completed by	Mental Retar	dation							24a. Was autor perfo	an osy ormod? 2 10 No	prior to	utopsy findings completion of c	available cause of
/iita	Physicien: The la r this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:				Oth	or		(Check only o	ne)			
	Physic rthis c aral dir	: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	Injury	28b. Time o		JA	4 LI NU		ne 5 🗌 Resid 28d. Describe l		6 □Other (Sp. ry occurred	ecify)	
Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification;	27. Manner of Death  1  Natural 5 Pending investigation  3 Suicide 6 Could not be determined  4 Homicide 5 Pending investigation  28a. Date of Injury 28b. Time of Injury Work?  M 1 Yes 2 No  28d. Describe how injury 28b. Time of Injury York?  M 1 Yes 2 No  28f. Location (Street an City of Town, State)									lural Route Nur	πber,		
ā	To the Hospitel or within 24 hours afte To the Funerel Dir. completely filled in I	edical Cer	(Check only 2 Medical 8	Physicien: To the bixaminer: On the bas	is of examin	owledge, deal	h occurred	at the tin	ne, date an pinion, dea	nd place, a	and due to the	cause(s	) and manner a d place, and du	s stated. e to the cause(	s)
)	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manne	Hend	920	290		e number 42580				te signed (Mor		
(	Ω:		30. Name and address of person v	vho comprete Dause	of death (Ite	т 23а) (Туре,							710		
1	DDb	10	Parmjit S. Aujl. 31. Date filed (Month, Day, Year)	22 Ba	Antroda Cian	nturn			B1ad	ensb	urg, MD	207	/10		
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 05497 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Davis February 5, Renate 2004 4:05P /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 1100 Owens Road Apt. # 616 Oxon Hill Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 29,1936 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex Days **Funeral** Months Min. Hours 1□M 2√F 536-50-9407 67 Germany Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County or 28a-f show the Medical Examiner must be notified at 1 Yes 2XX0 Directo Maryland | Prince George's Oxon Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1100 Owens Road Apt. # 616 20745 Germany Нета 23а 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes XXNo Specif-White Specify: þ 3 Widowed 4 □ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) Homemaker 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 1 and 2 should be filed within Health and Mental Hygiene. em 27 ls marked other then." Elementary/Secondary (0-12) College (1-4or 5+) Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Erika Agustus Herzog Holstin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If Item 27 Is P.O. Box 272 Clarksburg, West Virginia 26302 Christol Payne (Daughter) other February 7, 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 0 permit. Page Depertment of Important: If eny injury or 20058. Lee Crematory 2004 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 Va 2001 Kr Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertensive Cardiovascular Disease **Physician** /Medical Due to (or as a consequence of) **Examiner** Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Chronic Obstructive Pulmonary Disease and burial-trar Due to (or as a consequence of) Box 68760, physicien Cardiorespiratory Arrest the use as I attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown δ s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 1 Yes 2 No 3 Probably 4 Xunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes tirector, page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No the Hospitel or Attanding Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5X Residence 6 Other (Specify) ဥ 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural М 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29d, Date signed (Month, Dev. Year) 29b. Signature and title of certifier 2/10/04 D000 9162 Nasemunx 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Jafar Nazemian, M.D.

2004

31. Date filed (Month, Day, Year) FEB 1 1

DHMH 17 Rev 1/2001

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32. Resstrar's Signature

6196 Oxon Hill Road Suite 250 Oxon Hill, MD 20745-3100

State of Maryland / Department of Health and Mental Hygien 0 4 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2:22 Am Charlotte Ryland Davies Feb. 4 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6900 Indian Head Hwy. Bryans Road Charles If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7/11/1968 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 217-04-0939 35 Yrs. Director Wash Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other than "neturel", or items 23a or 28e-f ehow other traumatic event, the Madical Examinar must be multiled at MDCharles Bryans Road 1 Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6900 Indian Head Hwy. 20616 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 le marked other than "neturel", or tte 1 XNever Married 2 ☐ Married ☐Yes 2XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gloria Davies Leslie Davies 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Davies/Mother 6900 Indian Head Hwy. Bryans Road, MD 20616 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 2/5/04 Charlotte Hall,MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service Licenses AREHART-ECHOLS FUNERAL HOME, PA MO0945 P.O. Box 567 LaPlata, MD 20646 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition EAS ANC Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the death certificate be executed as the burial-tran and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physicien hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 MUnknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed. this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2₽No Be 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2☐ No 1 Inpatient ٩ 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending after death. М 1 □Yes 2 □No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) ye~ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) FEB 0 9 2004

32. Registrar's Signature

		1 - For State Registrar	Olato of Inc	-		of Health and <i>of Death</i>	i mornar rry	Reg. No.	2004	0549
Physici	an	1. Decedent's Name (First, Middle, Las		77			2. Dete of De Month	Day	y Year	3. Time of Death
/Media	al	William  4a. Facility Name (If not institution, give	Octavus	EVE	ersfie	LCI own, or Location of De	Febru		8 2004 County of Deet	
Examir	er	180 Jewell Road	Street and normony		Dunk		(a.u.)		Anne Ar	
neral		Social Security Number     6. Security Number	מאן ארב	e (In yrs. last birthda	y) If Under 1	Year If Under 24 H	n. 8. Date of Bi	rth ay, Year)	9. Birth	nplace (State or Foreiguntry)
ector		214-28-8979 <sup>12</sup> Usuel Residence of Decedent	7 7	75 Yrs.			Apr. 1	1, 1	928 Mai	ryland
4		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limit
edical Exacutrant transition notified at	Director	MD Anne Ari	undel		Dunk					1 ☐ Yes 2 🔀 N
peru	Dire	10e. Street and Number			10f. Zip Ci			10g. Citi	izen of What Cou	untry?
TANK.	Funeral	180 Jewell Road	12. Was Decedent	Ever in U.S. 1	3. Was Deceder	20754 at of Hispanic Origin?	(Specify Yes or No	0-	USA 14. Race - Amer	
O BURN	Fur	1 Never Married 2 Marned	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give	lo l	If Yes, specify	Cuban, Mexican, Pu	erto Hican, etc.)		Black, White	e, etc.
	ed by	3 Widowed 4 Divorced	Year or Dates:	952-54	cedent's Usual (			10h V	wh	ite
Month	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed)  College (1-4or 5	(Gi	ve kind of work of DO NOT use	done during most of w retired)	vorking	100. K	ind of Business/l	ndustry .
M S M	Com	12	College (1940) 3		ger and					griculture
event,	Be	17. Father's Name (First, Middle, Last)		7.7		18. Mother's N	lame <i>(First, Middle</i> la			
matic	2	Octavus Charles  19a. Informant's Name/Relationship (7	Eversfi		uling Address (S	itreet and Number or	- CUICL I		Maisac	
other traumatic		Margaret L. Evers			) Jewell		kirk. MD	207		,,
		20a. Method of Disposition  1 🖾 Burial 2 🔲 Cremation 3 🔲		20b. Place of Dis		of	Date	20c. Lo	cation - City or T	Town, State
>		'4 Donation 5 Other (Specify		St. Jam	es Cemet	tery 02-	12-2004	Lo	othian,	MD
any inju once.		21. Signature of Funeral Service Licens	76.			Address of Facility	-			- 00506
		23a. Part1. Enter the disease, or comp	lications that caused	the death. Do not e		Funeral Ho			wings, N	Approximate
cian		shock, or heart failure. List only o	ne cause on each lir	10. 12 A.	c (0)00	Cancer				Interval Between Onset and Death
lical		disease or condition resulting in death)	a. Due to (or as	a consequence of):		(Mic.				3 /201)
ier	344		b							
	mlne	if any, leading to immediate cause. Enter Underlying Cause Disease or injury	Due to (or as	a consequence of):						
g	Exar	that initiated events resulting in death) Last	Due to (or as	a consequence of):						
ne pri			d							
e as t	Physician/Medical	IF FEMALE:	32a Musa sutassa							
for use as the burial-transit	clan	in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	B □Ectopic pregi			2	23d. Date of deliv Month	rery Day Year
detached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		Caron loboo.					
De det	by P	Part II. Other significant conditions co		-	underlying caus	se given in Part I.				the cause of death?
should		Brostade	(4)(4)				1 🗆 '	Yes 2	PNo 3□Pro	bably 4 □Unknows
CV	Completed			····			24a. Was autop	osy	prior to co	opsy findings available ompletion of cause of
pad							1□ Yes		death?	2□ No
recto	o Be	25. Was case referred to medical examiner?	Hospital:	nt 2 ER/Outpati	ent 3 DOA	Othor	eath (Check only of			Z.1
1	-	27. Manner of Death	28a. Date of Injur (Month, Day			Injury at Work?	28d. Describe I			(y)
j	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Da)	<i>'Yeer)</i> Injury	м	1 ☐ Yes 2 ☐ No				
6	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ry - At home, farm, . (Specify)	street, factory, o	ffice	28f. Location (S City or Tox			al Route Number,
20		29a. Certifier 1 Certifying Phy	sician: To the best of	of my knowledge, de	ath occurred at t	he time, date and pla	ce and due to the	cause(s)	and manner as s	stated
	edical	(Check only 2 Madical Examone)	iner: On the basis of and manner sta	examination and/or	investigation, in	my opinion, death oc	curred at the time,	date and	place, and due to	to the cause(s)
mpletely rilled								00 / 0 /		
completely liked in by trie laneral director,	Me	29b. Signature and title of certifier				04 6314		29d. Date	e signed (Month,	Day, Year)

			For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of Health an rtificate of Death		giene 200	4 05500
I	Physici	an.	1. Decedent's Name (First, Middle, Last				2. Date of De Februal	ath	3. Time of Death
1	/Medic	al	Robert Joseph Eiz  4a. Facility Name (If not institution, give			4b. City, Town, or Location of D		ry 7, 2002	
	Examin	er	Calvert Memorial H			Prince Frederi			County
	Funeral		5. Social Security Number 6. Se			If Under 1 Year If Under 24	Hrs. 8. Date of Bird Min. (Month, Da	th ly, Year) 9.	Birthplace (State or Foreign Country)
	Director		372-62-9950 Usual Residence of Decedent	48	Yrs.		Feb. 4	, 1956 M	lichigan
	yland how		10a. State 10b. County	10c. Cit	, Town or Lo	cation			10d. Inside City Limits
	8e-fs	Director	MD Calvert	County Pr	ince F	rederick			1 ☐ Yes 2 📉 No
	with the		10e. Street and Number	-		10f. Zip Code 20678		U.S.A.	Country?
	death	Funeral	903 Augustus Driv	12. Was Decedent Ever in U.		Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, P	? (Specify Yes or No		merican Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23e or 28e-f show event, i're Medical Exer', in at itsust be inclifted at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 19' 1 XYes 2 No If Yes, Give		1 Tes, specify cuban, mexican, P 1 ☐ Yes 2 🌠 No Specify:	rueno Hican, etc.)	Specify: V	/hite, etc. /hite
215-003	2 hour		15. Decedent's Edu		16a. Deced	dent's Usual Occupation		16b. Kind of Busine	ess/Industry
212	ithin 7.	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	kind of work done during most of DO NOT use retired)	f working		
72	filed w Hygier sther th	Co	12. 17. Father's Name (First, Middle, Last)		Maint	enance Engineer	Name (First, Middle,	Leasing (	Company
and	0 = 0 >	To Be	Victor F. Eiza				Finocchie	,	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than sumatic event, I'm M	-	19a. Informant's Name/Relationship (T)			ng Address (Street and Number o			
	ages 1 and 2 should b int of Health and Ments t: If item 27 is marked y or other traumatic e		Mary E. Eiza (Wif			ugustus Drive,		20c. Location - City	
altimore,	Pages nent of h int: if ite iry or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	Temoval nom State		sition (Name of natory or other place)  Vianney Ch. Cem	eb. 11, n. 2004		ederick, MD
	permit. Page Department of Important: If any injury or once.		21. Signature of		22	. Name and Address of Facility	Lee Funera	al Home Ca	lvert, P.A.
m —	#9E # 9	N.	I MICHELL W. Low			25 Southern Mar			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	i. Do not ent	er the mode of dying, such as car	rdiac or respiratory ar	rrest,	Approximate Interval Between Onset and Death
ľ	Physician /Medical		disease or condition resulting in death)	a. Due to (al as a consequ	ience of):	- 1			-
	Examiner		Sequentially list conditions,	b. End st	Me	ewer Diseas	_		
	ed sit	ulner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	i⊣njoa of):				
Ĺ	icate be executed physician and s the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a consequ	ience of):				-
8760	ate be nysicia he bur	edlcal		d					
9	entifica ding pl		IF FEMALE:	23c. If yes, outcome of pregna	ncv				
Box	death certifi e attending od for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ø No	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year
д О	at the de by the a tached i	hys	9 Unknown	9□ Unknown					
	as the	þ	Part II. Other significant conditions co	ntributing to death but not resu	ilting in the ur	nderlying cause given in Part I.		obacco use contribute res 2 □ No 3 □	a to the cause of death?  Probably 4 Munknown
202	w require been sign	leted							
Ke	hysician: The law his certificate has t I director, page 2 s	Completed					— autop	rmed?   death	autopsy findings available to completion of cause of ? 'es 2 No
Division of Vital Records,	cian: ertifica ector, p	Bec	25. Was case referred to medical examiner?				Death (Check only of		3 22110
<del> </del>	Physi this o	2	1 ☐ Yes 2 ☒ No  27. Manner of Death	lospital: 12 Inpatient 2 2	ER/Outpatien		ng Home 5 Resid	lence 6 Other (S	pecify)
0	nding f ath. r: After e funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	200. 0630/100 11	iow injury occurred	
N N	r Attender death	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office	28f. Location (S City or Tow	Street and Number or m, State)	Rural Route Number,
	spitel or ours after neral Dir filled in		29a Certifier 12 Certifying Phy	sicism: To the best of my know	uladae desth		lane and due to the		
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical	(Check only 2 Medical Exami	ner: On the basis of examinat and manner stated.	ion and/or inv	occurred at the time, date and pi restigation, in my opinion, death o	occurred at the time, o	date and place, and c	as stated. lue to the cause(s)
	To the To the comp	Ž	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mo	onth, Day, Year)
•			+1900 m		22a) /T	D 3758		2/8/04	<i>L</i>
ı	15+1		30. Name and address of person who co	Beach Ld		ence he desice		20678.	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1	32. Registrate Signal		Coarles			